

Correspondence

Opioid use disorder: Long-term use of oral naltrexone for promoting abstinence

Naltrexone is an opioid antagonist that has clinical potential for use in patients with opioid dependence. While long-term use of opioid agonists such as buprenorphine and methadone has been well described, there is a lack of evidence of the long-term outcomes of patients being put on naltrexone.^{1,2} We describe a patient with opioid dependence who has been treated with oral naltrexone for about 8 years.

An 18-year-old male came to us in 2016 with opioid, cannabis, and tobacco dependence for 6 months, 3 years, and 5 years, respectively. He had behavioural disturbances, muttering to self, sexually inappropriate behaviour, and grandiosity for 6 months at the time of presentation. He was detoxified and started on oral naltrexone 50 mg per day (based on stated preference for opioid-free lifestyle), and olanzapine 10 mg was started for psychiatric symptoms which were remitted. Over the next 3 years, he did not relapse back to opioid regular use, though he stopped naltrexone for 5–6 days and tried heroin on 2 such occasions. However, each time his parents were vigilant and brought him to the outpatient services to restart naltrexone. Later, he tried heroin on 3–4 occasions but did not experience a high on consuming it as he was on regular naltrexone, supervised properly by family members. In 2017 he again had heightened psychomotor activity, decreased need for sleep, grandiose ideation, verbal and physical aggression toward family members, as well as muttering, giggling, and sexual disinhibition. The onset of symptoms was not related to the use of any specific substance such as cannabis. He was admitted, olanzapine was started and resolution of symptoms occurred in 14 days. Naltrexone was continued. Subsequently, in 2018, he presented with delusions of reference and persecution, followed by social withdrawal and then catatonia. Again, olanzapine 10 mg was started and the patient improved over the course of 5 weeks. An additional diagnosis of schizophrenia was the most tenable based on the psychiatric history.

The patient over the course of time took oral naltrexone and olanzapine regularly (Fig. 1). He was gainfully engaged in the family

business, changed peer groups to avoid substance-using peers, and joined a gymnasium to pay attention to his physical health. He relapsed to regular cannabis use subsequently and was admitted for a period ranging from 7 to 10 days for cessation of cannabis on four occasions between 2019 and 2023. He was admitted in 2024 when he reported consuming alcohol very frequently (5–6 drinks, 3–4 times a week) and acknowledging gradually losing control over drinking. His admission helped in the cessation of alcohol use, and again the possibility of stopping naltrexone was discussed. Even after 5 years of complete abstinence from opioid use, the patient willingly wanted to continue using oral naltrexone regularly, as he felt it safeguarded him against situations of peer influence and negative emotional state when he was likely to relapse. Regular use of olanzapine also seemingly ensured a lack of recurrence of psychotic symptoms. This suggests that stability in cases of psychosis can be effectuated with good compliance to antipsychotics. Dual diagnosis, i.e. the co-occurrence of substance use disorder and psychiatric disorder is a common occurrence in the clinical setting.

This case illustrates that long-term naltrexone can help some patients on their road to recovery from opioid use disorders. Naltrexone is reported as the fourth most effective treatment option for the treatment of opioid use disorder.³ Naltrexone is a particularly suitable option for patients who require an opioid-free lifestyle.^{4,5} This case also highlights the importance of retention in treatment, supervision by family members, and the potential of naltrexone in achieving and sustaining abstinence from opioids. By providing effective treatment and support, we can help individuals reclaim their functional lives and respect in society and overcome the challenges of living with addiction.

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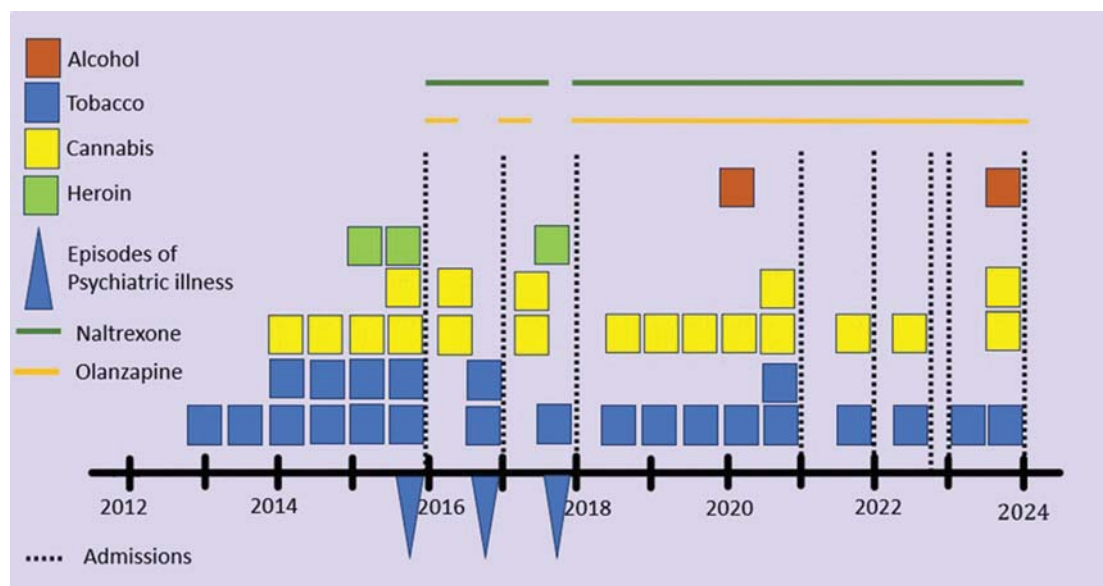


FIG 1. Life course of the patient

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Continuing Medical Education (CME): The experience from Hong Kong

We read with interest the article by Bhattacharya *et al.*¹ about the loopholes of the existing continuing medical education (CME) system in India. The main concerns expressed were credit hours, subspecialty relevance, disproportional participation for earning each CME credit point, whether for physical attendance to educational events or academic writing for journal publications. We would like to share our experience on CME in Hong Kong (HK).

In HK, specialists' CME are mainly regulated by the HK Academy of Medicine (HKAM).² Each subspecialty has her own college within HKAM, e.g. HK College of Obstetricians and Gynaecologists (HKCO&G),³ HK College of Physicians (HKCPhy), *etc.*⁴ Each college has assigned different categories of CME, namely active (non-passive) and passive participation. Attending conferences purely as audience is the only passive item. Otherwise, non-passive ways of obtaining CME include being the presenter (3 points for poster versus 6 points for oral presentation), invited speaker, moderator or panelist in conferences; continuous quality improvement projects for improvement of patient care; development of CME materials such as courses and workshops; development of new technologies or services such as artificial intelligence usage in clinical practice; serving as the examiner for professional qualification examinations including the membership and fellowship examinations; teaching undergraduate or postgraduate courses; enrolling in hands-on clinical attachment programme (more applicable to surgical specialties) in other training centres; publishing scientific articles and research in indexed peer-review journals; performing quality assurance, audits and activities for improvement of medical care; and self-study of scientific publications.

The minimum CME requirement is 90 points in a 3-year cycle, with the additional requirement of at least 15 active CME points. A point of CME activity is equivalent to 1 hour of participation as an attendee in a Formal College Approved Activity (FACC). Therefore, a specialist could not purely attend 90 hours of lectures to complete the cycle. She/he needs to be the speaker or chairman for at least 15 hours in FACC, conferences or publish manuscripts in indexed journals, *etc.* to acquire adequate active CME points in a 3-year cycle to sustain the specialist registration and practicing license.

For non-regular FACC, each educational event needs to seek respective colleges' approval for qualification of CME, and the number of points would be accredited according to the relevance of

content to that specialty. For example, in the Primary Healthcare Summit 2024 organized by the University of Hong Kong's Medical Faculty,⁵ HKCO&G awards 5 CME points for each day of event, and a maximum of 5 CME points for the whole 2-day function; whereas HKCPhy awards 2 CME points for each day of event, but a maximum of 4 CME points for the whole function. This arrangement would allocate relevant CME as per one's specialty without loopholes.

Concerning publications, PubMed indexed journals are the entry requirements, thus low-quality or predatory journals' publication would not be counted. Publications of original research articles or higher level of medical literature, e.g. meta-analysis, would be awarded 10 CME points each; whereas case report, editorial, letter to editor, *etc.* would only be awarded at most 5 CME points. Only first and corresponding authors would be awarded the full number of CME points, otherwise the remaining authors would just be awarded at most half of the CME points per publication. Peer-reviewers would also be awarded, with 1 CME point for each manuscript reviewed for an indexed journal, here there is no further subdivision on the type of manuscript reviewed.

Besides, undergraduate and postgraduate teaching could not contribute to >15 CME points within the 3-year cycle, while being an examiner of the college's professional examinations could not occupy >10 CME point. No system is perfect, and each one has its flaw. In the era of artificial intelligence, even with post-CME examinations, one could still cheat to pass.

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Clinical linguistic proficiency programme: An approach to achieve multilingual proficiency

The article on medical education in indigenous languages raises critical concerns about the future of medical training in India.¹ While the debate continues, we present the clinical linguistic proficiency program (CLPP), at present trilingual, developed at National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru for residents in psychiatry as an innovative and practical solution that