nominators, the reader can make comparisons at the population level. However, we would like to point out that given the results of the multivariate analysis (Fig. 2 of our article), in which there was a significant association between the occurrence of any adverse event and the presence of anti-Ov16 IgG4 antibodies (a surrogate for infection with *Onchocerca volvulus*), focusing on the presence of *L. loa* microfilariae as the only or main cause of adverse events would be misleading.

Sébastien D. Pion, Ph.D.
Michel Boussinesq, M.D., Ph.D.
Institut de Recherche pour le Développement
Montpellier, France
sebastien.pion@ird.fr
Joseph Kamgno, M.D., Ph.D.
Center for Research on Filariasis and other Tropical Diseases
Yaoundé, Cameroon

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**Case 37-2017: A Man with Unintentional Opioid Overdose**

**TO THE EDITOR:** The discussion of Case 37-2017 (Nov. 30 issue),1 a 36-year-old man with unintentional opioid overdose, calls for rapidly removing barriers to buprenorphine (Suboxone) treatment for opioid addiction. As practitioners in a Suboxone clinic, we urge caution and are concerned that this approach might prove to have a dark side. History has repeatedly shown that all opiates are innately addicting and should be used sparingly, at small doses, and for short periods. A thriving black market for buprenorphine already exists (one 8-mg tablet sells for $10 on the streets in Boston). Some addicts use this drug intravenously, in spite of naloxone being embedded in the product to prevent this. In Finland, where buprenorphine has been prescribed since 1997, it is now the most commonly abused intravenous drug.2,3

There is a striking paucity of research into tapering and discontinuing buprenorphine.4 The lowest available dose is 2 mg, yet a lower amount is often effective in patients. Daily, we witness the efficacy of this drug, as well as the extreme difficulty that patients have discontinuing it.

Barbara Scolnick, M.D.
Linda Ploude, L.I.C.S.W.
500 Congress St.
Quincy, MA
scolnick@bu.edu

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**TO THE EDITOR:** Raja and colleagues discuss a case that is common and that is central to the development of opioid-use disorder. This case shows how easily attempts to provide high-quality analgesia can result in addiction and accidental overdose. The discussants offer several potential solutions to manage accidental overdose, including the use of kits containing naloxone. An additional strategy may include the preferential use of buprenorphine for the management of acute pain.

Buprenorphine is well known for its unique safety profile, low potential for abuse, and efficacy in the management of opioid-use disorder. Only in recent years has it been recognized that buprenorphine has full agonist properties in terms of short-term analgesic efficacy.1 A recent meta-analysis of 28 randomized, controlled trials studying acute pain has shown that buprenorphine provides analgesia that is equivalent to that of morphine, even within 1 hour after administration.2 The high analgesic efficacy of buprenorphine, combined with the reduced potential for abuse, may help to strike a balance between high-quality analgesia and the risk of overdose and the development of opioid-use disorder.

Leigh White, M.B., B.S.
University of Wollongong
Wollongong, NSW, Australia
lw844@uowmail.edu.au
Ruan Vlok, M.B., B.S., B.Med.Sci.
University of Notre Dame
Sydney, NSW, Australia

Thomas Melhuish, M.B., B.S.
University of New South Wales
Sydney, NSW, Australia

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THE DISCUSSANTS REPLY: Scolnick and Ploude raise a concern about removing barriers to accessing buprenorphine treatment for opioid-use disorder. However, they erroneously state that “all opiates are innately addicting.” This statement is factually incorrect; opioid-use disorder develops in only a minority of persons who have exposure to opioids.1 Second, buprenorphine is used to treat opioid-use disorder, and long-term studies have shown that patients treated with buprenorphine no longer meet the criteria for addiction.2 Although Scolnick and Ploude are correct that illicit use of buprenorphine occurs, increasing access to legitimate treatment can reduce the diversion of buprenorphine, because most persons use it to manage withdrawal themselves either by choice or because they are unable to access care.3 Last, Scolnick and Ploude share the difficulties they have observed in persons discontinuing buprenorphine. Although some patients may wish to taper off buprenorphine after several years of remission, others continue the medication to maintain remission. This is similar to the management of other chronic diseases (e.g., hypertension or diabetes). We do not restrict access to insulin because patients cannot be tapered off it, and access to effective medication for the treatment of addiction should not be treated any differently.

Sarah E. Wakeman, M.D.
Ali S. Raja, M.D., M.P.H.
Massachusetts General Hospital
Boston, MA

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HIV Drug Resistance

TO THE EDITOR: In their Perspective article, Beyrer and Pozniak (Oct. 26 issue)4 suggest the rollout of the high-resistance-barrier drug dolutegravir as a solution to curbing the emerging threat of human immunodeficiency virus (HIV) drug resistance in resource-limited countries, along with implementation of the World Health Organization (WHO) global action plan.5 We support this approach but caution against presenting dolutegravir as a magic bullet. Focusing on medical-technical solutions alone risks encouraging complacency, whereas curbing resistance requires a multisectoral approach. There are also concerns about the current lack of long-term data from routine practice regarding dolutegravir.

First, preexisting resistance to the nucleoside reverse-transcriptase inhibitor (NRTI) backbone may potentially lead to so-called functional