

The Tragic & Predictable Known Unknown Challenges of Medetomidine and Xylazine – William Stauffer

Medetomidine and Xylazine have been in our drug supply for years, but their use is becoming increasingly prevalent on streets across America. They are typically being mixed with short acting opioids, primarily Fentanyl in order to enhance the synergistic effects. For readers, this is two plus two equals eight as anyone who ever had a martini on top of an older generation antihistamine may discover. Fentanyl, which has largely replaced heroin on the streets of America is shorter acting than heroin and so people use other drugs with it for this synergy. These drug combinations are powerful, highly addictive and lead to profound consequences.

The [CDC fact sheet on Medetomidine](#) indicates it was first detected in the US drug supply in 2022 in areas including Maryland and Pennsylvania. Xylazine has been in the street supply at low rates for decades and had been found initially in Puerto Rico and Philadelphia before becoming prevalent in the street drug supply around five years ago. By the end of 2024, [it was found in 72% of illicit opioid samples in Philadelphia](#). During the same time frame, detection of xylazine (previously the most common drug in combination with fentanyl on the streets), decreased from 98% to just 31% of street drug samples.



As I wrote about two years ago in respect to Xylazine, there was almost nothing in the literature in respect to supporting recovery from this drug beyond wound care and acute medical stabilization in a piece titled [Where Are They Going to Heal?](#) Unfortunately, little has changed since then. There has been almost no examination in the literature of how to treat people who have been using either xylazine or medetomidine beyond medical stabilization and withdrawal through to addiction treatment with the goal of long-term recovery. There are thousands more people every day becoming addicted to drug mixes from which we have no sense of what works to get them out of jeopardy and into long term recovery.

Out of sight out of mind. Invisible people. Drug use patterns for which we lack effective long term treatment protocols for. This is the tragic and predictable part. Like this one on in [The Lancet](#) in April, papers on it discuss treatment interventions only up to the point of withdrawal.

It is as if, once out of sight of primary medical institutions, the suffering of these fellow humans is no longer important enough to pursue. This is not new, there has long been a mentality of “treat them and street them” or as one emergency department physician who I discussed the phenomena once noted, people presenting with addiction in these settings are far too often termed GOMERS for “get out of my ER.” This mentality extends into our academic research which fails to focus on developing effective strategies for care beyond the first few short steps.

Questions that should be worth answering:

- What do we know about those who have been able to initiate and sustain recovery from these drug combinations?

- We need to understand how recovery is unfolding for persons who have been using these cocktails of drugs and what worked for them under what conditions and to highlight these examples so that our institutions can see that recovery does occur and our people are not hopeless.
- We need to know if there are particular treatment protocols that are more effective than others, as well as how and when to engage people to improve retention through to the point of sustained recovery.
- We need to know if there are particular communities or interventional strategies that have been more effective at supporting recovery efforts and conversely, which communities may experience more challenges for retention to the point that they are in long term sustained recovery.

Those are some of the known unknowns - there are others:

- The total bill for acute medical care, which tends to be quite costly, which has to be staggering but have not been fully tabulated even as they continue to mount exponentially.
- As these cases become turnstile, the time and resources required to respond by law enforcement and first responders also increase exponentially and we should calculate what these expenditures are.
- Secondary infections and compromised immune systems create a reservoir for emerging pathogens that are costly in resources and lives and these challenges also increase exponentially. We should factor these costs into how we calculate the value of interventions.
- We can anticipate increased spread of communicable conditions such as HIV and Hepatitis as we routinely fail to support persons in recovery efforts creating profound strain on resources and needless death which must be accounted for in order to support the requisite public health services required to effectively address it.

It all adds up to staggering butchers bill which measure in the billions. Interdiction or stopping the supply is important, but at least equally so is getting more people into sustained recovery in order to reduce demand. This follows the free-market axiom that wherever there is a market it will be filled. The most effective thing we can do is figure out how to get these people into long term recovery. This would reduce demand and result in a healthier communities. As I wrote about in Alcohol and Drug Abuse Weekly a few weeks back, [it Costs More to Kill Us Than to Help Us Get Back on Our Feet: Investing in Recovery is Cheaper and Yields Dividends.](#)

We know these things, but we do not act on this knowledge with strategies focused on long term recovery. It is as if we do not care if people recover. We follow this arc nearly every time we have an emerging drug use pattern over the long struggle to address drug use and addiction in the United States. And nearly every time we act surprised when we are caught flat footed in our limited and meager response. Yet we continue to do so very little to get ahead of this tragic and predictable pattern.

What other condition would we allow this to be how we handled it. Can we imagine addressing cardiac care in this way? When someone presents at the ED, they would use a defibrillator to establish normal heart rhythm and send them out, maybe with an old information sheet on the need to seek further cardiac care to avoid death, mostly denied by the funders.

Insanity is as they say doing the same thing over and over again and expecting a different result. If this dynamic does not meet that definition, nothing does. We must eventually learn that getting people into sustained recovery is the objective that must be our primary focus.

Like cardiac care, we do not fight cancer with an acute only focus as we know that does not work. The journey to remission does not end once the mass is removed, there is a long way to go from that moment to get to restored health. Failure to do those other things leads to an unacceptable outcome. Please tell me what is different here. Fundamentally there is none. This is a tragically predictable pattern we follow. Let's break the pattern and focus more efforts on understanding how to get more people who are using xylazine and medetomidine in combination into long term recovery. A vital element of doing so would require a research

focus on these areas of addiction treatment and recovery for persons using drug combinations that include drugs like xylazine and medetomidine.

Sources

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