Management of high risk MMT patients

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Faculty Disclosure

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  – Meldon Kahan MD has received funding from Reckitt Benckiser, whose product SUBOXONE IS being discussed in this program]
Mitigating Potential Bias

This presentation doesn’t focus on Suboxone
High risk patients

• Patients who need primary care
• At risk drinking and alcohol use disorders
• Hepatic, cardiac, respiratory and renal disease
• Patients on opioids for chronic pain
• Patients on benzodiazepines
• Cocaine users
PRIMARY CARE
Primary care: Guidelines

• Encourage patients to attend a primary care physician or team for ongoing age-appropriate screening and chronic disease management

• Have open and regular communication with the patient’s primary care provider
MMT and primary care

• Many MMT patients don’t attend primary care
• Not a regular habit for MMT patients
• MMT often separate from primary care
• MMT programs demand a lot from patients
Problems with lack of primary care

• Women in reproductive age group
  – Lack of screening, birth control
• Older men, women:
  – Lack of screening
  – Lack of chronic disease management (hypertension, DM etc)
• All patients:
  – Lack of attention to potentially serious medical, psychiatric symptoms
Strategies to connect patients with primary care

• Call and/or family physician personally and request they provide primary care
  – Overcomes medical stigma
  – Reassures FP that patient is stable etc
  – Coordinates care eg prescribing of opioids, benzo

• Make primary care part of ‘clinical stability’

• Don’t give 2 week carries unless they go to FP
AT RISK DRINKING AND ALCOHOL DEPENDENCE
Alcohol use

- Common among MMT patients
- Accelerates liver damage in Hepatitis C
  - Impact of moderate drinking not well understood
- Contributes to mood, anxiety, sleep disorders
- Increased risk of sedation, overdose, trauma
Hepatitis C

• No effect on treatment response or disease severity if < 30 grams alcohol (2 drinks)/day
• Poor treatment response if > 70 grams (4 drinks)/day
  – Sublette 2013
Screening and identification

• All MMT patients should be screened for alcohol use:
  – alcohol consumption history
  – Screening questionnaires, eg CAGE, binge drinking question, AUDIt
  – +/- GGT, MCV along with AST, ALT, Hep C serology
Brief interventions

• Study of 830 MMT patients
• 23% screened positive on AUDIT
• Brief interventions ass’d with reduced AUDIT scores at follow-up
  – Darker 2012
Brief interventions for at risk drinkers

• Information on low risk drinking guidelines
• Link between alcohol use and health (Hepatitis C, depression etc)
• Set treatment goal
• Daily diary
• Reduced drinking strategies
  – Alternate alcohol with non-alcohol drink etc
Pharmacotherapy

- Naltrexone (ReVia) contraindicated
- Acomprosate first line
- Topirimate
  - May be especially useful for methadone patients
  - Controlled trials have shown it reduces severity of alcohol and cocaine dependence
    - Kampman 2012, miller 2011
Pharmacootherapy

- Disulfiram
- Controlled trial - decreased cocaine and alcohol use in MMT patients
  - Carroll 2012
- Baclofen
- Shown to reduce consumption in patients with cirrhosis due to hepatitis C and alcohol
  - Leggio 2012
Coverage

• Gabapentin, baclofen – general benefit
• Topiramate – LU if patient had seizures
• Disulfiram – through pharmacy.ca
Alcohol withdrawal

- Methadone patients in alcohol withdrawal should be given smaller doses of lorazepam (e.g., 1-2 mg) rather than diazepam
MMT AND ORGAN DYSFUNCTION
Hepatic disease

• Stable liver dysfunction does not appear to affect methadone levels

• Methadone patients can become very sedated with decompensated cirrhosis
  – Decrease dose
  – Avoid benzodiazepines
    • Prolonged half life of benzodiazepines can trigger encephalopathy
  – Monitor QT interval (due to increased meth levels)
Renal, respiratory illness

- Methadone level not affected by renal insufficiency
- Closely monitor for toxicity if acute renal failure

- Incomplete tolerance to respiratory depression
- Monitor closely if acute respiratory illness
- Avoid abrupt cessation of methadone
- Withdrawal can cause cardiorespiratory complications
Prolonged QT interval: risk

• Methadone dose
• Medications eg high dose citalopram
• Hepatitis C
  — Gholami 2013
ECG screening

• 150 MMT patients given baseline and follow-up 6 months
• 76% had increased QT interval
• 7% had interval > 450 msec
• 2% had interval > 500 msec
• Suggests to me that ECG should be done at 6 months regardless of dose
• Krantz 2008
ECG screening (2)

- 500 MMT patients screened with ECG
- 20 (4%) had QT interval > 500 msec
- Reduced on follow-up
- No predictive risk factors except dose
  - Katz 2013
Targeted monitoring

Monitor QT interval if:

• Methadone dose above 120 mg
• Cardiomyopathy from any cause
• Possible ↑ methadone serum level
  – eg acute hepatic, renal failure
• New medications that affect QT

Avoid rapid methadone tapering
  – can trigger cardiorespiratory instability
OPIOIDS AND MMT
Chronic pain in methadone patients

- Study of 490 patients in two MMT programs
- 48.5% reported clinically significant pain
- 38.8% of pain patients were on opioids
- Pain patients had higher methadone dose, more medical illness, more severe depression
- No increased drug use
  - Dhingra 2013
Opioid use in Ont MMT patients

• 3456 of 18,759 methadone patients (18.4%) received 1 or more opioid prescriptions of 7+ days' duration
• Median number of opioid prescriptions dispensed per year was 11.9
• Most frequently prescribed opioids were codeine and oxycodone
• Nearly half (45.8%) originated from non-MMT prescribers and pharmacies
  – Kurdyak 2012
Opioid use in methadone patients (2)

• “Many patients receiving methadone maintenance therapy in Ontario receive overlapping prescriptions for other opioids, often for extended periods... many such prescriptions may be duplicitous.”
  — Kurdiak 2012
Risks of opioid use

• Little research on safety, effectiveness of methadone combined with other opioids

• Risks:
  – Difficult to monitor opioid use with UDS
  – Methadone-opioid interactions
  – Relapse to opioid addiction
  – Diversion (3400 MMT patients receiving opioids who don’t need them)
  – Double doctoring
Case

• MMT patient on high doses of opioids, benzodiazepines from family physician
• Neither MMT nor FP knew of the other
• Patient died of an overdose
• ODB currently does not inform MMT physicians that patient is receiving an opioid (or vv)
Acute pain

• MMT patients tolerant to opioid analgesia
• May require opioids in higher or more frequent doses than non-tolerant patients
• Discuss risk of relapse with patient
  – Some patients prefer non-opioid analgesics
Acute pain (2)

• If prescribe opioids in addition to methadone:
  • Choose an opioid that the patient hasn’t misused in the past
  • Dispense small amounts
  • Limit script to # of days that opioids usually needed for the acute pain condition
Methadone for addicted patients with chronic pain

• Patients with both pain & addiction have substantial pain relief with daily methadone

• Randomized trial of prescription opioid addicts with chronic pain:

• Both methadone and buprenorphine subjects had 13% reduction in pain scores

   — Neumann 2013
Methadone and pain

• Methadone analgesia lasts only 8 hours
• Split dose if the patient experiences severe pain unrelated to withdrawal several hours after the morning dose
• Wait until patient is on stable once-daily dose and receiving 5-6 take-home doses per week
Regulatory issues

- Need Health Canada exemption to prescribe methadone as an analgesic for non-addicted patients with CNCP
- With CPSO addiction exemption, can prescribe methadone as analgesic & as opioid agonist for patients with concurrent addiction and pain
- Prescribe as per MMT guidelines
Indications for opioids in MMT

• Only one indication:

• Severe neuropathic pain unresponsive to all other medications incl anticonvulsants and antidepressants

• Prescribed in coordination with a pain physician

• Tight controls over dispensing with free communication to prescribers
Management

• Open communication with FP
• IF you find out the patient is on opioids:
  • Take over prescribing and taper if:
    – Patient on high dose (200 mg MED)
    – No evidence of need (fibromyalgia, low back pain)
    – Little evidence of benefit (continues to report severe pain with no improvement in function)
    – Concern about diversion
Benzodiazepines

• Benzodiazepine use associated with increased substance use & psychological distress
  – causal relationship has not been established

• Bzd elevates risk of overdose
MMT and benzo use

• Chart review of 172 MMT patients at CAMH (1997-1999)
• 35% were regular/problem users of benzos
• Regular/problem users were more likely to be addicted to prescription opioids
• Experienced more overdoses
• Had greater psychiatric comorbidity
  – Brands 2008
Management

• Cohort study: Improved mood in patients starting MMT who stopped benzodiazepines and went on antidepressants when started on MMT
  • Schreiber 2008
Management (2)

- Comparison of 70 MMT patients who abused benzodiazepines, who were either tapered off or maintained on clonazepam
- 78% of maintenance group stopped bzd abuse
- 27% of detox group stopped bzd abuse
- Effective for Axis I patients but not Axis II

- Weizmann 2008
Management (3)

• 6 month Pilot study of 196 MMT patients
• Bzd abusers started on clonazepam maintenance 6 mg/d
• Tapered to lowest effective dose
• 75% stopped abusing over study period
  – Bleich 2002
Management

• Suggest take over prescribing from family physician unless patient on small night time dose

• Taper with clonazepam to lowest dose, esp if the patient is:
  – on multiple daily doses
  – Shows signs of misuse or is on a high bzd dose
  – is on a high methadone dose
  – is on other sedating drugs
COCAINÉ AND MMT
Cocaine

• Associated with worse outcomes
• Overall, patients reduce cocaine use once started on MMT
• Reduction is modest compared to opioid reduction
• Reduction not related to dose
• Probably related to contingency management and counselling
Disulfiram

• May be effective in MMT patients if current alcohol abuser (Carroll)
Topiramate

- RCT: Topiramate (max dose 150 mg bid) plus extended release amphetamine salts reduced cocaine use vs placebo (Marianni)
- RCT: Topiramate in cocaine and alcohol using patients increased cocaine abstinence rates but not alcohol (Kampman)
Other treatments

• Systematic reviews: Antidepressants and antipsychotics are not effective (Pani) (Alvarez)

• Other medications with disappointing results:
  – Methylphenidate
  – Modafinil
  – Disulfiram (for cocaine without alcohol problems)
  – Amphetamines – may be promising but also risks
    – more study needed
Recommendation

- Consider topiramate if:
  - Also using alcohol
  - Expresses a desire to quit cocaine
  - Has anxiety disorder or labile mood
  - Has cocaine-induced seizures