Opioid Agonist Therapy: To Maintain or Not To Maintain - A Case Discussion

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Agenda

- Introduction
- Case Studies focusing on opioid agonist maintenance (4 cases / 40 min)
- Q and A (10 min)

FDA-Approved Medications for Opioid Use Disorder

- Methadone
- Buprenorphine / Naloxone
- Buprenorphine
- Naltrexone tablets
- Naltrexone (IM)

Clinical Issues in Maintenance Treatment

- What is the appropriate duration of treatment?
- What is an effective, office-based approach to maintenance?
- What are the common pitfalls seen in maintenance treatment?
- What should I be monitoring and checking?

Case #1: Abby

- 34 yo woman with opioid use disorder
  - Non-medical use of opiate pills from age 20-25
  - Progressed to heroin at age 25
  - 3 relapses, 2 rehabs from age 25-30
- Started on buprenorphine/naloxone at last rehab, 4 years ago
  - No relapses during maintenance
  - Daily dose 8 mg

Case #1: Abby

- Just completed PhD in Neuroscience
- Starting post-doctoral fellowship in another state
- She wants to stop taking buprenorphine/ naloxone because “I don’t want to keep taking this forever”
- Denies urges and cravings
- Occasional 12-step and no therapist

Questions

- What do you say to Abby?
- What are the risks and benefits of tapering off buprenorphine?
- How would you go about tapering Abby off buprenorphine?
- What is the likelihood of relapse?

Case #1: Abby

- After a discussion, you decide to begin a taper of buprenorphine by 2 mg every week and to follow her every 2 weeks in the office
- After 6 weeks, she has been able to reduce to 2 mg total per day
- She says she is “scared” about jumping entirely off because of what she’s read on the Internet

Questions

- How do you manage this situation?
- Would you prescribe ancillary meds to taper her off?
- What other approaches can be used to safely taper her off?
- How do manage her fear of withdrawal symptoms?

Questions

- When discontinuing buprenorphine, which approach works best – slowly tapering off or stopping cold turkey?
- What ancillary meds can or should be given during discontinuation of buprenorphine?

Case #2: Chris

- 54 yo wm, prescription opiate abuse for 5 years due to lower back pain
- Sought out office-based buprenorphine from another patient of yours
- Co-occurring ADHD and generalized anxiety disorder

Case #2: Chris

- Uncomplicated induction with buprenorphine
- Does well for first 8 months
- Sporadic psychotherapy support
- Compliant with office procedures
  - Urine drug testing
  - Liver function tests
  - Attends appointments regularly

Case #2: Chris

- 9 months into treatment, Chris loses his job (downsizing) and subsequently loses his insurance
- Has difficulty navigating insurance world and begins to worry that he can't afford buprenorphine
- Misses his last two appointments and requests phone refills

Case #2 : Chris

- You tell him that you won't refill the buprenorphine until he makes an appointment. He says he can't afford the office visit but he wants you to phone in generic buprenorphine and says if you don't he will go into withdrawal.

Questions

- How do you handle this situation?
- What is your level of responsibility and duty for Chris?
- What would you say to Chris, especially if he can't afford maintenance treatment anymore?

Case #2: Chris

- You agree to prescribe a two-week supply of buprenorphine contingent on him making an appointment.
- He does not show for the appointment and you don't hear from him for 3 weeks.
- He then calls saying he can't sleep, has diarrhea and is craving opiates.
- He is begging for his "usual dose of buprenorphine"

Questions

- What are your management options at this point?
- How long can buprenorphine withdrawal symptoms last?
- What are the potential risks of prescribing or not prescribing?

Case #3: Sal

- Patient is a 50 yo male on methadone maintenance 80mg daily.
- Has been in the clinic for 10 years; gets 13 take homes.
- Works full time and needs to travel for work.
- Wife is OK with methadone, but complains he tends to fall asleep at night while watching TV.

Case #3: Sal

- Found your services through the SAMHSA provider directory.
- He wants to transition from methadone to buprenorphine.
- He claims his clinic is aware of his desire to switch to buprenorphine.

Questions

- What is an effective, office-based approach to transition a methadone patient to buprenorphine?
  - What and how would you prescribe?
- How much should the MMTP be involved in this transition?
- What are the possible complications of this transition?

Case #3: Sal

- You transition Sal from methadone to buprenorphine, using mono product.
- After 2 weeks, you tell him that you are now going to switch him to buprenorphine/ naloxone film.
- He takes the buprenorphine/naloxone film for one week but calls up complaining of "nausea" and that he thinks he is allergic. His wife says he's still sleepy.

Case #3: Sal

- What could be happening to Sal?
- How do you approach his sleepiness?
- How do you handle maintenance patients who want or request buprenorphine mono product?

Case # 4: Matt

- 24 yo male with prescription opiate addiction for two years
- Co-occurring alcohol use disorder
- Moved from NY to LA and needs a new buprenorphine treatment provider
- Very involved in 12-step in NY, with sponsor and commitments

Case #4: Matt

- Has been on buprenorphine 4 mg maintenance for 18 months, without side effects and relapse.
- Within 3 months of living in LA, he has tried several different meetings and has been told by members and his LA sponsor that he is not sober because he is on buprenorphine.

Case #4: Matt

- He asks you what he should do – he does not want to stop going to this 12-step group because of the fellowship but he does not want to stop buprenorphine because he feels very good (no urges).
- He notes that he does not have access to prescription opiates.

Questions

- What can you say to Matt to help manage this conflict?
- When is it appropriate for physicians to work with sponsors, 12-step groups?
- Would tapering off be an appropriate course of action?

Summary

- Opioid Use Disorder is a chronic, relapsing disease.
- Duration of treatment with opioid agonist requires an individualized plan of monitoring and support.
- Even if patient is not on medications, they should still remain under treatment.

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