Methadone Today

The official newsletter of DONT--BY PATIENTS, FOR PATIENTS July 2003 Volume VIII Number V

Father of MMT Celebrates 90th Birthday

by Dr. Andrew Byrne, General Practitioner (NSW, Australia).

*[*This was written in May, a month when **Methadone Today** was not published. However, we want to belatedly honor the birthday of Dr. Dole, the father of methadone.]*

This week marks the 90th birthday* of Dr. Vincent P. Dole, the co-originator of methadone maintenance treatment for opiate dependence. Even in the face of legal threats, Dr Dole and his team persisted with their pioneering work, which has now become mainstream in most of the developed world.

I have had the privilege of knowing Dr Dole for the past decade, meeting up with him each year at his Rockefeller University office on New York's east side. On aging, Dr Dole says that as when very young, the elderly have to start learning again, this time, the various ways of coping with deteriorations in the body. Despite some arthritis, he is still mobile and uses his mental energies for tasks beyond many half his age. One current interest is the benefit, psychological and otherwise, of face masks in the SARS epidemic.

Dr. Dole's consistent view has been that methadone should be treated like any other strong, effective medication, to be prescribed with appropriate supports and safeguards by adequately trained doctors. This principle has allowed its use around the world in stemming the toll from opioid dependency. Adherence to such normal therapeutic principles has facilitated the parallel use of buprenorphine, LAAM and other drugs in appropriate situations. Dr. Dole's views on detoxification are both pragmatic and compassionate.

I know that all in our dependency community and beyond will join with me in wishing this fine man well on his achievements.

Our best wishes to Dr. Vincent P. Dole and wife Margaret on this happy day!

Editor's Note: To say that Dr. Dole "face[d]... legal threats," does not give readers a true appreciation of what he was willing to risk. He was heavily pressured by the Bureau of Dangerous Drugs (the predecessor of the Drug Enforcement Agency [DEA]) to cease his research. Had Dr. Dole and Dr. Marie Nyswander (his research partner and wife, who since passed away), submitted to these threats, opiate agonist treatment might not exist today. ***(Cont p. 3)***

ANNOUNCEMENT:
Database on Treatment Providers

Addiction Treatment Watchdog (http://www.atwatchdog.org) has a new online Clinic Report Database. This database will benefit patients and clinics by acting as a consumer reporting resource for Medication-Assisted-Treatment. Patients and providers are welcome to submit reports. If you don't have access to a computer, we will send a hard copy report to submit if you e-mail us at:

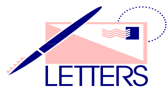
A.T. Watchdog, P.O. Box 555, Platte City, MO 64079

The Clinic Reports will be available online at the A.T. Watchdog website (see web address above).

Such a "Clinic Report Database" is a resource sorely needed. Current and prospective methadone patients have little to go by when deciding on a treatment provider. Unless an individual happens to know current or former methadone patients who can give a recommendation, virtually the only resource available up until now was the telephone book. Many treatment providers only have their name, address and telephone number in the Yellow Pages, and others are not even listed in the Yellow Pages. Only a small number of large methadone clinics have a more descriptive Yellow Pages advertisement--even then, it is not advisable to rely on an advertisement. More importantly, few ads have the information listed in A.T. Watchdog's database. For instance, an ad is not going to tell you that patients spend an hour in line waiting to dose every day.

It has quickly become apparent that accreditation is not going to stop bad treatment. AT Watchdog continues to receive complaints from patients about treatment providers; the introduction of accreditation requirements has not put a damper on the number of complaints.

The Clinic Report Database has valuable information about treatment providers, such as urinalysis and take-home policies. The information comes from patients who are invited to submit a report on their treatment provider. One of the pluses of this database is that it lists information about all treatment providers-- ***(Cont. p. 3)***



Dear Methadone Today,

I have admired you for years. I have been on MMT for seven years (this time). I started for the first time in 1987 but was not serious about giving up my drug of choice at that time and didn't stay in the program for long (a few months). After numerous problems with the police and child protective services, my husband and I decided to get serious about our addiction and returned to the program again in 1989.

We attended NA, got our son back and remained on MMT. It saved our lives and gave us a new start. We stayed clean and became productive members of society; it also helped us become better parents.

In 1990, I got pregnant, and being on only 13 mg, I quickly detoxed for the sake of my baby. However, my addiction got the better of me again, and in 1997, I once again went into methadone maintenance treatment and have been in treatment ever since. I'm doing good and am not ashamed of my treatment. It has made my life better in many ways.

Unfortunately, my husband and I separated in March 2001, and he decided to go off methadone shortly afterward, saying he couldn't afford it any longer. He died a few months later. The cause of death was listed as "drug abuse". He also had severe liver disease from his years of abuse. It has been extremely difficult, especially for our two children. My then 17-year-old son, along with his friends, found him dead on the floor. I'm doing all right now considering what I have been through. I am, however, extremely afraid of going off methadone. I am detoxing VERY slowly, and if need be, I will remain on MMT for as long as I need it. **-Maria**

Dear Maria,

We are glad that you have gotten your life back together after the death of your ex-husband. Your husband's story puts a face on the treatment accessibility problems we have written about in prior issues of ***Methadone Today***. The weekly cost of methadone treatment in the U.S. is $60-120*, depending on ***(Cont. p. 3)***

Dental Problems and Addiction Treatment

by Dr. Andrew Byrne, General Practitioner
(New South Wales, Australia)

**"Dental problems in addiction treatment subjects. Does methadone rot teeth? Can we prevent dental decay?"*
Main speaker Dr Peter Foltyn (Dentist, St Vincent's Hospital). Concord Hospital Dependence Seminar (May 20, 2003).

Dr Hallinan began by reminding us how much a smile is worth at a job interview, as well as the drawbacks of bad breath and poor nutrition which are so common in dependency cases. He invited the large audience (of over 40) to benefit from Dr Foltyn's 20-year experience in treating such patients in his practice at Darlinghurst, Sydney.

Dr Foltyn gave us all a timely reminder of the importance of good dental care and the pitfalls of a number of factors countering dental hygiene. He dealt with a number of important issues for patients with drug and alcohol problems, including xerostomia (dry mouth). When the salivary mechanism is inhibited, there is a break-down of the normal manner of diluting and removing debris, resulting in a lower pH and an acidic environment for the teeth. This allows penetration of the enamel, especially at the gingival margins where it is thinnest and where it joins the dentin. Thus, for patients who are taking antidepressants, anti-cholinergics and for some patients on methadone, there is a need to counter dry mouth. The use of 'swish and rinse' at the time of medication (and at other times during the day and night) can be very effective in protecting the teeth. Chewing gum can stimulate salivation and sugar-free gums are now available.

Regular brushing after each meal, however, is still the mainstay of treatment/prevention. We were told that a medium brush with small, angled head is best and that much modern toothpaste is either unnecessary and, in some cases, may cause irritation to already delicate buccal surfaces. This, we were told, was largely due to the foaming agent used in virtually all proprietary brands available in supermarkets. Sodium laurel sulfate has been shown to increase irritation in some people, but there are only two current brands available (largely at chemist shops) which omit the use of this chemical. The other agents common to most toothpastes are an abrasive agent as well as a detergent. It may be that brushing with just water is as effective and less irritating to some people than when using some pastes. We were told that while some electric tooth brushes have certain advantages, they are not necessary for optimal dental care.

Another common cause of xerostomia in the hospital setting is head and neck radiotherapy. It can be so devastating for the teeth that occasionally extractions are recommended before radiation starts since healing is often so protracted afterwards. Also, infections can set in, including one type of osteomyelitis which is almost untreatable.

We were shown some shocking technicolour (sic) anatomy-atlas-type dental soft-porn to demonstrate these matters. Once getting over the initial shock of close-up dental views, we then looked at projections of sequential x-rays of dentition in various states of dissolution (literally). Some were in AIDS cases, others nutritional deficiencies, radiation stomatitis and cancer cases, including Kaposi's sarcoma.

Plaque was discussed at length, as well as the various ways of dealing with it. It was pointed out that in some cases plaque can extend under the gingival margins, requiring tooled removal by the dental surgeon. Other exposed areas were dealt with and we were reminded about individual brushing, tooth by tooth on the three surfaces, lingual, buccal and interfacial. Gentle but purposive brushing to engage the gingival margin was stressed. Minor bleeding in inflamed areas is to be expected for a time but continued bleeding should always be examined by the dentist. Flossing to clean the inter-dental surfaces should also be done regularly. Three times yearly check-ups in patients at increased risk was also stressed.

Topical fluoride should be applied in such high-risk individuals and the dental fluoride 'tray' is the most effective way. It is like a mouth guard which should be smeared with fluoride paste/gel and inserted for ten minutes before retiring. Dr Foltyn said that dentists will apply the same thing for a fee, but to do it oneself regularly is more appropriate for most of our patients. It would appear that fluoride can be effective even in late stage dental wear and tear.

We were advised to tell our patients with poor dentition to avoid strong mouth washes with alcohol bases such as Listerine. A water based mouth wash with antiseptic is more appropriate and less likely to cause irritation. Chemists can advise on the types.

The methadone 'syrup' marketed in Australia still contains sorbitol which is a sugar *(Editor: U.S. methadone is sugar-free)*. Although it is not actively absorbed and is safe for diabetics, as a sugar it is still a fuel for oral bacteria and alcohol with other constituents are not likely to help dental hygiene. The sugar-free 'solution' Biodone should probably be our 'first line' product and the 'syrup' mainly used for those sensitive patients who are unable to tolerate the pure medicine. But importantly, Dr Foltyn says that this must not give any false sense of dental security as xerostomia will occur to the same degree with both products.

The use of buprenorphine may also cause dental problems although one would hope to a lesser degree than oral methadone syrup. We need to watch carefully with this new medication and advise regular dental check-ups.

There are many other issues which had to be left to another session, and there was lively discussion on this pressing issue. We need to examine better analgesia during and after dental surgery in dependency patients. Antibiotics in those with heart murmurs, prosthetic joints, etc need to be addressed. Putting more resources into high risk cases should be a public health priority as good teeth can improve self confidence, job prospects and even romance!

Dr Foltyn can be contacted for more information. He can send e-mail copies of the excellent hand-out for dental recommendations in xerostomia (dry mouth) as well as the grizzly photographs. He requests that you place "Concord Seminar" in the title. [Dr Foltyn's e-mail: pfoltyn@stvincents.com.au]

Editor's Note: Contrary to popular beliefs, methadone does not rot out teeth--as indicated above, the only potential problem is that many methadone patients experience dry mouth as a side effect. After being on maintenance treatment for a period of time, many of the side effects associated with methadone go away entirely or decrease in intensity, but often the dry mouth side effect persists to some extent. Even for those [methadone patients or the general population] who do not experience dry mouth, good oral hygiene will help prevent or delay dental problems. Dentists lecture their patients about regular brushing and flossing for good reason. Good oral hygiene is even more important for individuals suffering from dry mouth, a side effect of not only methadone but a large variety of medications, as well as alcohol, many illicit drugs, etc. It is safe to say that if those with dry mouth follow the oral hygiene recommendations discussed above, such individuals (i.e., methadone patients) should be no more prone to dental problems than anyone else.

Methadone patients should keep in mind that there are many other issues that may impact dental health. For example, during periods of "active" addiction, many drug addicted individuals do not maintain a healthy diet or ***(Cont. p. 3)***

Father of MMT (from p. 1).
Prior to methadone maintenance treatment, the relapse rate for opiate addicts was roughly 90-95%.

From his actions, it is clear that he did not conduct his research merely for recognition or prestige but out of a true desire to help individuals suffering from opiate addiction. Over the years, he has continued to help improve treatment for methadone patients and will not hesitate to openly criticize the treatment practices of many treatment providers, which are not in the best interest of patients.

It is a shame that the majority of both methadone clinic counselors and patients have never even heard of Dr. Dole. We are also disappointed that only a small minority of methadone clinics provide the high quality treatment envisioned by Dr. Dole.

Those readers who want to learn more about Dr. Vincent P. Dole and his thoughts on opiate agonist treatment should see the February and March 1998 issues of ***Methadone Today***, "An Interview with Dr. Vincent Dole." ***(If you are interested in ordering these or other back issues, see the bottom of page 4.)***

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Database (from p. 1).
rather than simply being a list of complaint reports, which only list negative information about providers individuals have complained about.

Because AT WATCHDOG relies on patients to provide the information about treatment providers, we urge patients to submit a report about their methadone clinic/treatment provider at the address or website listed above--it only takes a few minutes to submit a report, and you will be helping others find the treatment provider that's right for them.

Dear Maria (from p. 1).
the area of the country--this makes treatment unaffordable for the majority of opiate addicts in need of treatment**. In addition, drug addicts like your husband, who do not have health insurance, may not be able to afford treatment for medical conditions related or unrelated to their addiction (i.e., liver disease).

In regard to your pregnancy, withdrawing from methadone (a.k.a. "detoxing") is contraindicated--even if the pregnant patient is only on 13 mg/d. It is a shame that due to ignorance or bad advice, you "quickly detoxed for the sake of [your] baby." Doing so may endanger the developing fetus--and could put you and your baby in even more serious peril should you relapse during pregnancy as a result. You indicate that you did relapse at some point after your pregnancy. Most likely this would not have occurred had you remained in maintenance treatment, though we're guessing that you were already in the process of tapering when you became pregnant, since you state that when you got pregnant, you were only on 13 mg/d. Please understand that we are not criticizing you. It is your methadone clinic doctor and obstetrician who did not give you the correct information and advice--and may have even advised you to quickly withdraw off methadone, which is totally wrong. The important thing is that you are back in treatment and doing well and that you and our readers know the facts about pregnancy and methadone treatment.

Finally, you are right to be apprehensive about withdrawing; the relapse rate is quite high among patients who have withdrawn from methadone. Methadone patients should not taper off methadone unless they truly want to do so. Those who are simply submitting to the wishes of family members, employers, etc., are bound to relapse. As far as success rates go, a very gradual taper regimen is the best withdrawal method, so you are right to take it "VERY slowly." Good luck and thank you for writing in.

**These figures refer to private treatment providers that are not subsidized. Public or government subsidized clinics may offer lower, "sliding scale" rates where the amount charged depends on the patient's income (lower income patients pay less). Very few areas have public/subsidized methadone clinics that provide long-term maintenance treatment and which do not have a long waiting list. These figures also do not account for office-based/medical maintenance treatment or extended take-home situations where the patient is only attending a clinic or doctor's office once or twice a month (such treatment may be less expensive). Even in states that permit office-based treatment or extended take-homes, patients must be in treatment at least a year before they can be eligible for more than once a week take-homes; thus, this is rarely an issue for those having trouble affording treatment.*

***Only a small number of opiate addicts who cannot afford to pay for treatment "out-of-pocket" are on, or are eligible for, Medicaid, and in only about one-half of states does Medicaid even cover methadone treatment. Of those individuals who actually have private health insurance coverage, only a small fraction have an insurance policy that will cover methadone treatment, and then the policy may only pay a small portion of the cost of treatment.*

Dental Problems (from p. 2).
good oral hygiene, may not see a dentist regularly and may be chronically using substances that are harmful to their teeth (i.e., crack cocaine or alcohol). It's also possible that they already had dental problems that were not apparent or that symptoms of which were masked by illicit drug or alcohol use.

Finally, dental problems may simply be related to the patient's age--by 40-50 years old, it is common for some dental problems to occur. By coincidence, many methadone patients initiate maintenance treatment around or shortly below the age at which serious dental problems often start occurring. The point is that while patients should be conscious of the potential problem of dry mouth and the need to take steps to prevent dental problems related to dry mouth, they should also recognize that methadone is not otherwise harmful to teeth and not responsible for every dental or periodontal problem that occurs.

If you have a question for our Medical Advisory Board, please write or e-mail us (see contact information on page 4).

ANNOUNCEMENT: Updated TIP Publication to be Printed

CSAT (Center for Substance Abuse Treatment), a federal government agency, is preparing to publish a new TIP (Treatment Improvement Protocol) next year: ***Medication-Assisted Treatment for Opioid Addiction***. This new TIP will replace a few of the current TIPs, which cover opiate agonist treatment. The old TIPs have outdated information and are based on the old federal regulations, which have been replaced by the new accreditation guidelines. CSAT has asked people from various disciplines to review a draft version of the TIP. Patient advocates are among the reviewers.

The publication of this TIP is important when so much myth and outdated information abound in the field of opiate agonist treatment. Reliance on obsolete information can cause serious harm to patients. For example, outdated treatment practices may put both the pregnant methadone patient and her developing fetus at risk. Before sufficient research had been conducted in this area, medical professionals believed that a dosage reduction was the safest course for the health of the fetus. In some cases, the pregnant patient was completely withdrawn from her methadone medication. But once this area was thoroughly studied, researchers discovered that many of these treatment practices were harmful to both pregnant patients and the developing fetuses. In fact, methadone maintenance caused no harm to the fetus--even with relatively high doses of methadone. On the other hand, dose reductions/tapering off methadone may endanger the fetus--and may result in a relapse, which could certainly result in serious harm to the fetus. On top of this, clinical experience has shown that many pregnant methadone patients need a dose INCREASE some time during pregnancy (usually in the third trimester), due to certain physiological changes (i.e., increased renal blood flow to the fetus during this time).

We would like to be able to tell you that all physicians stay up-to-date on research and current medical practices, but this is not the case. This is precisely the reason patients need to educate themselves and not rely on their physicians, nurses and counselors to know the facts about a given treatment. To take just one example of the dangers of relying on the provider for such information, we discovered one Detroit area methadone clinic using "Consent to Treatment" forms with outdated information. The section on pregnancy and breast feeding gave incorrect recommendations (i.e., that methadone patients should NOT breast feed, as this could harm the infant). This contradicts current expert advice, which is that breast feeding while in methadone treatment is safe and poses no harm to infants. And the section on LAAM did not contain a warning about the link between LAAM and cardiac arrhythmia. Although the clinic in question does not actually offer LAAM, we still consider this a serious omission.

The issue of outdated information and recommendation does not only apply to pregnancy. For instance, expert recommendations regarding adequate dosing practices has changed over the years. Doctors no longer speak of a "blockade dose" in terms of a fixed amount. The idea of "individualized dosing" has now taken center stage, and research over the years has demonstrated the need for higher doses in many patients. Diseases such as HIV and especially hepatitis C, which did not exist when early methadone maintenance treatment research was conducted, impact opiate agonist treatment. Some of the medications used to treat these diseases may affect the body's metabolism of methadone. In the case of hepatitis C, the disease itself may affect the body's metabolism of methadone. Depending on the disease's progression, the patient may metabolize methadone very rapidly or, less frequently, more slowly. Finally, new medications for various diseases, illnesses and conditions come out all the time, and consequently, medication interactions are an area which must be constantly updated (i.e., new medications used to treat HIV, TB, etc., are found to speed up methadone metabolism.

We hope that CSAT's publication of this new TIP will help patients and medical professionals alike. The problem is that opiate agonist treatment provider staff often have never even looked at the TIP/TAP publications or similar texts. We suggest that patients ask their counselor and other treatment provider staff if they have the TIP/TAP series. SAMHSA will send the publications to one's home or office completely free-of-charge. We believe that the TIP/TAP publications relevant to opiate agonist treatment should be required reading for methadone clinic counselors and, certainly, clinic physicians. We also suggest that patients get these publications--it is in the patient's best interest to know more about their treatment than what is listed on a "consent to treatment" form. The TIP/TAP texts are very informative, yet easy to understand. With all the stigma and discrimination that surrounds methadone maintenance treatment, methadone patients need to educate themselves–and others.

To order a free copy of the TIP/TAP publications, call 1-800-SAY-NOTO (the revised TIP referred to above is still at the draft stage, so it will not be available until some time in 2004).

Beth Francisco, Senior Editor - (810) 250-9064
Aaron Rolnick, Managing Editor
Methadone Today **(Vol. VIII, No. V)**
P.O. Box 90337
Burton, MI 48509-0337
http://www.methadonetoday.org
E-mail: bethfrancisco@netzero.net

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