

Methadone Today

The official newsletter of DONT--by patients, for patients January 2005 Volume X Number I

TIP/TAP Series: Hospitalization and Treatment of Pain for MMT Patients

by Nancy Rose, Former DONT Secretary

The late Nancy Rose was a Detroit Organizational Needs in Treatment (DONT) Officer and frequent contributor to Methadone Today. This article was printed in Methadone Today several years ago; a friend of the Managing Editor reminded us of the importance of the issue of pain management, particularly while in the hospital.

The "TIP/TAP" Series are books put out by the U.S. Department of Health & Human Services, which give the **federal government's recommended guidelines and protocols** for all substance abuse treatment clinics and programs. This column explains the government's recommended guidelines for treating methadone maintenance treatment (MET) patients for pain and during hospitalization (all bold and emphases are mine).

In TIP 20 (Matching Treatment to Patients Needs in Aged Substitution Therapy), it states: "During a medical crisis requiring hospitalization, it is important for the physician providing methadone treatment to communicate with the hospital attending physician.... The [hospital physician] should be informed of the patient's methadone dosage and the date on which methadone was last received. It is **extremely important** that the treating physician be aware that the patient will probably require **larger** amounts of medication for anesthesia and that adequate pain relief will require that the patient receive [his or her] normal methadone dose... **plus additional medication**" (p. 55).

It states in TIP 1 (State Methadone Treatment Guidelines)*, "Methadone maintained patients occasionally require medical, surgical, and dental procedures.... When the conditions or procedures cause pain, serious errors in patient management commonly occur. As a result, pain is either not treated or seriously undertreated. The practitioner often believes that a patient taking... methadone daily could not possibly need anything else for pain. **This is absolutely incorrect.** It should be crystal clear (Ct. p. 4)

Dear Methadone Today,

I was on the program for seven short months. But I am currently detoxing on my own. I have been without methadone for seven straight days now and have not had any crutches except for ten measly Valium (but as you can imagine they are already gone). I have never hurt more or been more depressed in my life. My biggest problem is an old injury--I was in a major car accident ten years ago and crushed the left side of my face; it hurts so bad. In my own opinion, the methadone program is just another drug dealer, however, I can't honestly say I'll never go back. Much more of this hell, and I'll go back sooner rather than later.

I can honestly say that for a short time I thought that the program saved my life, but now I am just flat out confused. I am only 22 years old, and I have been using drugs for half of my life now (since right after my accident).

I just don't know what to do. But I am however open to suggestions. Thanks for letting me share with you. **-Depressed**

Dear Depressed,

We assume from your letter that you were on methadone treatment for opiate addiction--not just pain management. There are people with chronic pain issues who do not suffer from opiate addiction that go to a methadone clinic as a last resort when they cannot find a doctor willing to continue prescribing opioid pain medications to them. If this is the case, you have two distinct medical issues--1). opiate addiction; and 2). chronic pain on the left side of your face. Based on your letter, we are also guessing that NSAIDS alone are not sufficient to relieve your chronic pain (NSAIDS are non-narcotic pain medications, that include OTC [over the counter] drugs like aspirin and ibuprofen, as well as prescription medications like Celebrex). Part of your problem is that even if you successfully withdraw from methadone, you will continue to suffer from chronic pain; if NSAIDS alone are not sufficient to manage the pain, you may need opioid pain medication, which could precipitate a relapse.

The chronic pain issue aside, you are (Cont. p. 3)



Dear Methadone Today,

I work in a hospital on a psychiatric unit. It has been 45 days for this patient's withdrawal from methadone, she has trouble walking and states she is still in withdrawal, my question being what is the length of time it takes to be totally withdrawn and off the methadone. **-TA**

Dear TA,

First of all, we are alarmed that this patient was abruptly withdrawn from methadone (i.e., she stopped taking the medication, rather than tapering off of methadone over a period of time). This is a barbaric and counter-productive method of withdrawal--even if the patient is given non-opioid medications such as clonidine or Valium to ease withdrawal symptoms. In the case of moderate-to-severe opiate withdrawal, these medications are woefully inadequate at alleviating withdrawal symptoms.

We couldn't tell you exactly how long it takes for a patient to be totally withdrawn from methadone; that is, that the patient is

no longer experiencing withdrawal symptoms. Keep in mind that methadone is a long acting opioid, so in comparison to heroin and other short acting opiates, withdrawal from methadone is less intense but of a longer duration. Following abrupt withdrawal from a maintenance dose of methadone, it is not unusual for serious withdrawal symptoms to last 45 days or longer. Insomnia seems to be a particularly persistent symptom of methadone withdrawal and opioid withdrawal generally.

Furthermore, given the physiological nature of opiate addiction, the patient may never feel completely 'normal'. Put simply, in most opiate addicts, the addiction is caused by an underlying chemical imbalance in the brain--or at least, this chemical imbalance is a major factor in their opiate addiction. In the majority of addicts, this chemical imbalance appears to be a long term or permanent problem; that is, the imbalance does not correct itself when the individual abstains from short-acting opiates for a period of time. This is the likely reason why the relapse rate (Cont p. 3)

Report on APSAD Conference by Dr. Andrew Byrne, General Practitioner (New South Wales, Australia)

The following are excerpts only, covering the most noteworthy and relevant topics discussed at the conference. Thanks to Dr. Byrne for his very informative and incisive report.

The second formal day of proceedings had an emphasis on prisons and law enforcement. Michael Farrell's talk was entitled "Tackling problem drug users before, during and after prison. Dealing with a high risk environment". He reminded us of the problems of suicides in jail as well as deaths in recently released prisoners, citing numerous studies showing the greatly increased risks of overdose in the days after release. It was for this reason that methadone was introduced into all prisons in New South Wales almost two decades ago. It appears that methadone treatment is still not routine in British jails and indeed, most other countries' jails, despite the evident need and benefits.

Tim Mitchell spoke on the potential advantages of using the active enantiomer ('R') of methadone in preference to the cheaper racemic version ('RS') generally available.* He had searched the literature, especially from Germany where this has been used in clinical practice for many years for historical reasons. While there were some negative effects noted from the inactive form, these appeared mild in most people, except at high dose levels. It was shown that the metabolism of the two forms could be quite different and one might induce the metabolism of the other. The best information might be obtained from those who have transferred regularly from the German program to other European locations where doses have to be doubled to yield the same agonist effect.

Ian Kronborg gave an interesting talk on sleep disturbances in methadone maintained patients, pointing out how complex this field has become. There are dozens of specific sleep pathologies recognised and now, a particular one associated with opioid maintenance. All practitioners should remind those with insomnia about regular 'sleep hygiene' as some methadone patients were found to require only simple advice to improve disturbed sleep patterns.

Lula Kamal gave a disturbing account of the reasons English patients had left maintenance treatment in past episodes. Methadone doses had been 'too low' with 'cravings', 'withdrawals' and 'continued heroin use' given as the reasons in many of her confidential questionnaire subjects in London. A question from the audience confirmed that poor quality treatment appears to be rife in London with little patient involvement in decision making about dose levels. It is still a mystery why the mean methadone dose in England remains reportedly below 40mg (where it probably should be double this for optimising benefits) ... and no wonder that as a consequence methadone has a bad name amongst patients, doctors, journalists and the community generally. It is most surprising that the major Addiction journals, Colleges, NAC and NHS have not conceded the existence of this parlous state of affairs, nor have they done anything to rectify it. Comparisons with other European countries show an ongoing spate of adverse consequences from overdoses to HIV and hepatitis. The matter is so grave that even quite conservative people are now calling for heroin prescription for addicts.

Richard Hallinan from our own surgery then presented evidence of hypogonadism and sexual dysfunction in opioid treated men. He recommended that practitioners include these issues in clinical assessments and in monitoring of on-going opioid replacement treatment.

In a second paper, Dr Hallinan then described the use of receiver operating characteristic (ROC) analysis to define

statistically optimal thresholds for methadone dose and plasma concentrations (100mg daily; 250ng/ml R-methadone; 300-400ng/ml for racemic methadone) in relation to continuing heroin use in MMT. Measuring plasma concentrations apparently did not help to predict continuing heroin use in MMT.

Dr Comer spoke about her work with long acting depot naltrexone for heroin relapse prevention. Her own study from Columbia University used ~200 mg and ~400 mg doses, measuring blood levels and responses to injected heroin in the 6 weeks following (yes, an American heroin trial!). Some developed skin irritation at the naltrexone injection site and one attempted suicide during the trial. This is consistent with Miotto and Ling's findings and might be associated with an accompanying depression although Comer said that it was not thought to be a result of the treatment.

**The following is a simplified explanation of the difference between a formulation containing only the active enantiomer ('R') of methadone vs. a formulation containing the cheaper racemic version ('RS') of methadone. There are chemical compounds that are not identical, yet do have the identical number and amount of atoms. Basically, one substance is the 'mirror image' of the other substance. So, a certain atom may appear on the right hand side of the molecule on the first substance and on the left hand side of the molecule on the second substance. 'R' methadone is the active version, meaning this is the version of methadone that is effective, whereas 'S' methadone has seemingly no effect on the human body (this is not exactly true, as there seems to be somewhat of a difference in effects between a formulation containing both versions ('RS') of methadone vs. one containing only the active version ('R') of methadone).*

As alluded to in the above article, the methadone formulations used in the United States and most other countries contain both versions of methadone ('RS'). The formulation containing only the active version ('R') is more expensive, so it is generally not used. Hopefully additional research will be conducted to determine which patients, if any, would benefit from 'R' methadone, and based on this research, maybe it will be offered in the U.S. and other countries to those patients.

Editor's Note: It is a shame that U.S. prisons, with few exceptions, do not provide methadone treatment to opiate addicted inmates--or even to inmates who were already in methadone treatment prior to incarceration. Numerous studies over the years have demonstrated that methadone treatment greatly reduces or eliminates criminal activity among opiate addicts.

However, Dr. Michael Farrell reveals another compelling reason to provide methadone treatment to inmates. As he points out, the risk of overdose among recently released prison inmates is high. This is because his/her tolerance to opiates is much lower than it was prior to incarceration when s/he was abusing illicit opiates. Note that the relapse rate is extremely high among recently released prisoners. And even among opiate addicted inmates who continued to abuse illicit opiate while in prison, the risk of overdose upon release is high; their opiate tolerance level is likely lower than it was before they were incarcerated.

Providing methadone treatment to prison inmates and encouraging inmates to continue methadone treatment after release will considerably reduce the likelihood of overdose on illicit opiates following release from prison. Methadone treatment will greatly reduce the chances that an inmate will relapse following release from prison; furthermore, the risk of overdose, should a relapse occur, will be much lower. Methadone treatment provides some protection from opiate overdose. Prisons have no good excuse for not providing methadone treatment.

Dear Depressed (from p. 1).

attempting to withdraw from methadone (we do not use the word 'detox', which is a medically inaccurate and stigmatizing term) the wrong way. Methadone patients who abruptly stop taking the medication in an attempt to withdraw from it are putting themselves at extreme risk of relapsing. The probability that you will successfully withdraw from methadone using this method and remain abstinent from opiates in the long term is very low. Given that you are having such a difficult time, maybe you should consider getting back on methadone. Then once you are stabilized on an adequate dose, if you are still determined to withdraw from methadone, you should gradually taper off of the medication under the supervision of your methadone clinic physician. Even using the slow taper method, the relapse rate is high (80-90%)--but it is still much better than withdrawing from methadone 'cold turkey'; with cold turkey withdrawal, relapse is a virtual guarantee.

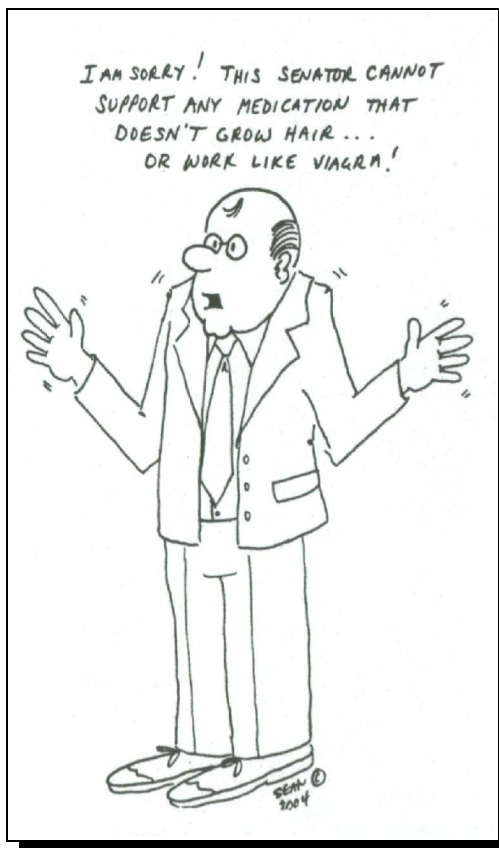
When discussing this issue, we always stress that the problem is not that "methadone is hard to get off of," but rather that this is the nature of opiate addiction. So many opiate addicts would not require methadone treatment in the first place if achieving and maintaining an opioid-free state were so easy. 'Cold turkey' withdrawal from methadone is rarely successful without relapsing but neither is 'cold turkey' withdrawal from heroin and other short-acting opiates. For opiate addicts--at least those who have a serious physical dependence on opiates--a gradual methadone or buprenorphine taper is the best method for attempting to become opioid-free without relapsing.*

Drs. Dole and Nyswander developed methadone maintenance treatment precisely because there were no successful treatments available at the time. No matter what 'detox' method was used, only a small percentage of opiate addicts managed to remain opiate-free. Methadone maintenance is a highly effective treatment for opiate addiction, but you need to realize that it is not a cure. In other words, it only works as long as you continue to take the medication. If you abruptly stop taking it, you are at risk of relapsing and will also experience withdrawal symptoms.

We strongly disagree with you when you state that "the methadone program is just another drug dealer." Notwithstanding the shabby treatment of patients by some methadone clinics, methadone treatment providers cannot be compared to an illicit drug dealer. Methadone clinics are providing a medical

treatment to patients. We have detailed in other issues how methadone treatment is not merely, "substituting one addiction for another." While methadone patients are physically dependent on methadone, they are not addicted to the medication. Furthermore, if methadone treatment was effectively treating you for opiate addiction (i.e., you were not abusing illicit opiates and other drugs, not experiencing opiate cravings, and not suffering from opiate withdrawal symptoms), maybe you should resume methadone maintenance treatment. If methadone treatment alone was enough to manage your chronic pain**, then this solves that problem as well--otherwise, you may need a higher dose of methadone than you were previously on and/or a split dose.

Again, if at some point in the future you decide that you really want to withdraw from methadone, we would suggest that you do so using a gradual taper under your methadone clinic physician's supervision. Whatever you decide, we wish you luck.



**Researchers originally thought that buprenorphine would be easier to taper off of than methadone, but studies so far indicate that the success rate is pretty much the same for a buprenorphine taper as for a methadone taper. One limitation of*

buprenorphine is that in opiate addicts or methadone patients with a high level of physical dependence, buprenorphine can actually trigger withdrawal symptoms. To avoid withdrawal symptoms, methadone patients need to taper down to at least 30 mg/d before transferring to buprenorphine.

***In stabilized methadone maintenance patients, a maintenance dose generally provides no analgesia (pain relief) [see "Hospitalization and Treatment of Pain for MMT Patients," on page 1]. However, we have talked to patients who find that their methadone dose provides minor pain relief for their chronic pain issues. Even in these cases, a split dose may be necessary.*

Dear TA (from p. 1)

is so high among opiate addicts in abstinence-based drug treatment. The only highly effective treatment for opiate addiction is opioid maintenance treatment (i.e., methadone maintenance or buprenorphine maintenance). This also explains why opiate agonist treatments like methadone therapy are often only effective as long as the patient continues on the medication. Methadone maintenance treatment should generally be regarded as an effective treatment for opiate addiction, but not a cure. The usual analogy to the use of insulin to control diabetes is used: while insulin effectively manages diabetes, it is not a cure, so if a diabetic ceases using insulin, diabetic symptoms return.

We hope that the psychiatrists at your hospital educate themselves better about the nature of opiate addiction and opiate agonist treatment. Oftentimes, withdrawing a dually diagnosed patient from methadone results in a worsening of whatever mental illness the patient suffers. This is a serious concern in a patient with a mental illness severe enough to warrant inpatient treatment at a hospital. Of course, withdrawing such a patient also puts him/her at high risk of relapse which, besides being harmful in itself, is likely to worsen whatever mental illness the patient happens to suffer from. In our opinion, psychiatrists who do not have a great deal of experience in the treatment of opiate addiction should resist the temptation to withdraw methadone patients while in the psychiatric unit for an issue other than opiate addiction. We hope this helps, and please understand that your questions are always welcome, even though we sometimes offer constructive criticism.

Treatment of Pain (from p. 1).

that the methadone-maintained patient is fully tolerant to the maintenance dose of methadone and thus experiences no analgesic effect. . . . At this stable dose, the inadequate treatment of pain in methadone-maintained patients commonly leads to disruptive behavior by angry and frightened patients and discharge against medical advice. . . ." (pp. 54-55)."

TIP 1 gives the following guidance: "Short-acting opioid analgesics are appropriate and effective in MMT patients if used properly. Because of the established cross-tolerance, [the patient] may require **larger-than-usual** doses and more frequent administration. Attending physicians may need both firm guidance and reassurance from experienced addiction medicine professionals because the attending physicians are not accustomed to using such large narcotic doses" (p. 55).

Most of the above column is all quoted straight from the TIP/TAP books because this is a **very** important subject, and it cannot be said that I misinterpreted **any** part of it! Most of us, as MMT patients, dread going to hospitals or doctors even more than non-addicted people, because we are usually seriously undertreated for pain. Most health professionals are not informed about methadone treatment, and many methadone clinics amazingly haven't even heard of the TIP/TAP books. You may want to find out if your clinic has a set of them; if not, tell them they can order a **free** set (or you can do it for them) by calling (800) SAY-NOTO.

Also, if you are going into a hospital or plan to see a new doctor, get a letter from your clinic doctor explaining the above TIP/TAP advice. My own clinic has a form letter already made up for patients who ask for one--I carry one with me at all times. A sample clinic letter, borrowed from Dr. J. Thomas Payte, is printed in the September 1997 issue of **Methadone Today**. There is also a sample clinic letter in one of the TIP/TAP books, and another is be available on the internet at www.capqualitycare.com.

Don't suffer needlessly! Educate your health care professionals about MMT, if necessary, **before** you go into the hospital. It is best that you have someone who understands methadone and who would be willing to advocate for you while you are hospitalized. You will probably not be feeling your best, and you may be incapacitated during the worst of your stay. Even during the best of times in the hospital environment, it is difficult to keep on top of things. Your advocate will have the ability to move around, make calls, and insist that you are treated properly instead of being brushed off as, "the junkie who just wants all the narcotics s/he can get."

**Since this article was written, TIP 1 and some of the other TIP/TAP books are being rewritten to include changes and advances in opiate agonist treatment, and to cover the new federal regulations (information about government regulations contained in TIP 1 and some of the other TIP/TAP books is no longer accurate, such as the rules governing take-homes).*

***There is also a sample clinic letter in one of the TIP/TAP books, and others may be available on the internet. While the content of all these letters are pretty similar, they may have minor differences as far as what is included in them and what issues they emphasize, so you may want to compare a few sample letters and choose the one that you prefer. If you bring a sample letter to your clinic physician s/he may be willing to just sign it, or they may have their own letter that they provide to their patients. Besides the issues mentioned above, the letter also lists medications that are contraindicated in methadone patients (**Methadone Today** also offers an inexpensive medical alert card to patients that lists contraindicated medications--such a card is highly recommended, so in the event of a medical emergency, medical personnel will know what medications you are currently taking, what medications are contraindicated, and other such important information [to order a medical alert card, see below]).*

****Much of the above information also applies to buprenorphine, however, the treatment of pain in buprenorphine patients with opioid medications is somewhat more complicated (unlike with methadone, the patient's buprenorphine dose may need to be temporarily discontinued--as buprenorphine is a partial opioid antagonist, it may block the effects of other opioids). For this reason, buprenorphine patients should obtain a letter from their buprenorphine treatment physician, rather than attempting to adapt one of the aforementioned letters by substituting the word "buprenorphine" for "methadone".*

Editor's Note: We recommend that methadone patients going into the hospital draw up a Medical Power of Attorney contract--and it might be a good idea to draw up a Living Will at the same time, if desired. A Medical Power of Attorney gives a designated person(s) the right to advocate and make medical decisions for you in the event you are incapacitated (i.e., anesthetized, sedated or unconscious). A Living Will provides specific instructions to medical personnel. Even for healthy individuals, it is a good idea to draw up such documents in case of an emergency. Consult your hospital and/or attorney for more information.

Beth Francisco, Senior Editor - (810) 250-9064
Aaron Rolnick, Managing Editor
Methadone Today (Vol. X, No. 1)
P.O. Box 90337
Burton, MI 48509-0337
<http://www.methadonetoday.org>
E-mail: bethfrancisco@sbcglobal.net

DONT is a non-profit 501(c)3 organization dedicated to helping patients achieve quality methadone treatment, preserve patient dignity, provide greater public understanding, eliminate discrimination toward methadone patients, and promotion of harm reduction policies.

Won't you please help us cover costs of the newsletter, web site, etc. Your donations are tax deductible.
IT DOESN'T MATTER WHAT OTHERS DO--IT'S WHAT YOU DO THAT COUNTS. PLEASE, do your part--GIVE WHAT YOU CAN.

This newsletter is made possible by subscriptions and donations only

- Single-copy **patient/individual** subscription to **Methadone Today** \$20 yr
- DONT membership only - \$10/yr.
- Subscription to **Methadone Today with membership** - \$27(save \$3)
- Single-copy **clinic/institution** - \$35 yr /10 issues - you may reprint up to 100/mo.
 - \$50 yr. - to 500 copies/mo. \$100 - to 1000 copies/mo. \$150 - unlimited
- Clinic subscription (\$350/yr. - 100 copies/mo. will be delivered to clinic).
- Back issues - \$10 each - Vol. I - IX (or \$35 all issues to date)
- Donation of \$ _____ to send **Methadone Today** to someone who cannot afford it or to educate policy makers, clinic staff, and/or general public.
- Enclosed are _____ 37-cent (or other) stamps to help with postage.
- Donation of \$ _____ to the **Methadone Today** web site.
- Personalized, laminated methadone MEDIC ALERT card (send your name, clinic's name, clinic's phone number, & self-addressed, stamped envelope [SASE] - cannot be processed without preceding) - \$5 with any order, \$8 without order.

Name _____ Phone: _____

Address _____

City/State/Zip _____

E-mail: _____

For Medical Alert Card only:

Clinic Name _____ Clinic Phone: _____