

Methadone Today

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Myths of Methadone (part 1)

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How much do you know about methadone? Test yourself. How many could you have answered correctly? If you are thinking about possibly working as an advocate for **Advocates For Recovery Through Medicine** and joining us, then you need to be able to answer all these questions. Even if you are not, but you are a patient, you still need to know for yourself; therefore, when you hear these myths you can dispute them. Knowledge is power!!! Then we all grow.

1. IS METHADONE MAINTENANCE TRADING ONE ADDICTION FOR ANOTHER? TRUE OR FALSE

[When] [m]ethadone is prescribed as in maintenance therapy, it acts as a normalizer rather than a narcotic. The patient is able to function in every physical, emotional, and intellectual capacity without impairment. It is orally effective and does not produce mood swings, tranquilization or narcotic effects.

Methadone patients can obtain college educations, perform all types of intellectual and physical skills, marry and raise families. Methadone does not produce dependency as do other medications prescribed. **For many addicts the alternative to methadone maintenance is: continued illicit use of heroin, criminal behavior, jail and premature deaths.**

2. PREGNANT WOMEN SHOULD WITHDRAW OR AT LEAST LOWER THEIR DOSE OF METHADONE SO THAT THE BABY IS NOT BORN DEPENDENT. TRUE OR FALSE

A pregnant woman who abuses opioid drugs may seriously damage both herself and her unborn child. While methadone itself does not eliminate all potential problems, participation in methadone maintenance treatment greatly reduces the risks of illness or even the death in mother or child.

Methadone is the only approved medication for treating opioid addiction during pregnancy. When properly used as part of a methadone maintenance treatment program, there has been no reported evidence of harmful effects of methadone to the mother or unborn child.

A respected group of experts, gathered by The Institute of Medicine in 1995, concluded that methadone (**Cont. p. 3**)

My Hospital Experience

by L.D.

After having read patient stories in **Methadone Today** about their experiences in the hospital, I was a little concerned about my upcoming hospital stay. I was going in to have a bowel resection--a surgery that is fairly common but could nonetheless be regarded as major surgery. Besides, abdominal surgery is known to involve quite a bit of pain--so pain control was definitely a serious consideration.

From my prior appointments with the doctor that was to be performing the surgery, I felt that he was a very good doctor--however, I never got around to asking him about pain control and my being on methadone treatment. I was confident that I was in good hands as far as the surgery itself, but I was a little apprehensive about post-surgical pain control.

I did find **Methadone Today's** information regarding the treatment of pain in methadone maintained patients quite helpful. I would definitely advise methadone patients about to undergo surgery to read the recent issues of **Methadone Today** that deal with this topic. I also had the benefit of having a friend to advocate for me while I was in the hospital, who is knowledgeable about these issues. This is very important, as I was certainly not able to advocate for myself in the first few days following surgery. After major surgery and post-surgical hospitalization, I would definitely recommend that anyone being hospitalized--especially those on methadone treatment--have a family member or friend to advocate for them while in the hospital.

Despite whatever reservations I had, my experience in the hospital was a good one--or at least, as good as is possible under the circumstances. The hospital staff was always very attentive to pain control. In fact, the nurses would periodically ask whether I was in pain and if I needed a dose of pain medication. The doctor had an ongoing order to administer pain medication as needed. The doctor also continued my dose of methadone, which at first had to be administered IV, as I was unable to drink or eat anything. The only time being dosed was at all an issue was the day of the surgery--they were supposed to dose me in the late afternoon [after the surgery], but the doctor neglected to order it. This is (**Cont. p. 3**)

Dear Methadone Today,

I was a subscriber for a year or two but have lost touch.

Have you run any articles or letters about experiences in people who went from methadone to Subutex (buprenorphine without naloxone)? I have read the clinical stuff, and it says that some withdrawal occurs since the Subutex replaces the methadone, but I cannot get a handle on how bad the transition would be or how long, without finding out from someone who has "been there", and it is hard to trust the doctors when they have not had the subjective experience, especially if a patient is trying to do it while holding down a job, managing a family, and otherwise trying to act as normal as possible (i.e. not depressed, not all sweaty--you know what I mean).

If you can refer me to a prior issue, I will look it up. If not, I would like to communicate with anyone who has been through the experience. My point of reference would be 20 mg/day of methadone (and no temptation whatsoever for any other opiates) to between 8 and 16 mg/day of Subutex.

Thanks for all you do (you published one of my letters a few years ago about how it gets harder to reduce the methadone the farther down you go, because the percentage change in reduced dosage gets larger even though the mg reduction stays the same.) -Anna

Dear Anna,

We do not recall printing any articles or letters from people who transferred from methadone to buprenorphine. We certainly welcome and encourage anyone who has switched to buprenorphine to write us about their experience.

As far as withdrawal symptoms during the transition, it likely varies from person to person. At least one thing you have going for you is that you are stable on 20 mg/day--a low enough dose to transfer to buprenorphine. Methadone patients stable on a significantly higher dose than this are at a disadvantage and likely to have a more difficult transition to buprenorphine, as they would have to taper down to a lower dose of methadone before they could even transfer to buprenorphine.

In theory, [given that you are currently stable (**Cont. p. 3**)

Dear Doctor,

I live in Australia, and my partner Craig is on biodone. He has Crohn's disease (which is not currently active, although he does get major pains from the biodone) and was put on the program to control his addiction to Oxycontin. While the methadone program is well used in Australia, finding knowledgeable people on the subject is very difficult, and any guidance you could give would be very helpful.

Craig started on methadone, and was switched to biodone when the chemist changed products. He stayed on the same dose but has been experiencing withdrawal systems for two weeks. The symptoms are easing now, but I was wondering if he is on the same dose of the ingredient methadone (in the biodone); what is he withdrawing from? When he was on methadone, he tried detoxing at 10 ml per week, then at 5 ml per week, and ended up in hospital with severe pain, and consequently his dose was bumped right up again. If he detoxes off the biodone now, will it be easier as he is not withdrawing from the other ingredients in the methadone?

Secondly, we know that Craig metabolizes foods very fast. Since being on the program he has not been able to live a normal life. In the morning he is fine; he takes his dose about 8 am, but by lunchtime—early afternoon he starts 'coming down' and gets huge depressive mood swings and major problems with a lack of energy, lots of pain (directly related to taking the biodone) and is always in bed by 7 pm. I have heard that splitting his doses may prevent the 'come down'—even out the mood swings—and maybe even help with the severe constipation and energy drain. Is this fiction? Would you suggest, given the problems described, that splitting his doses is a good option? He really wants to get back to work and lead a normal life, but on methadone/biodone, each day is a struggle.

Thank you so very much. -**Suzie**

Dear Suzie,

Biodone is pure methadone solution without sugars, preservative, alcohol, etc. It is better for the teeth, liver and probably bowels. However, it is absorbed slightly faster than the gummy syrup in some people—and thus the effect may not last quite as long, so some need a slightly higher dose (10% at most in my experience) when transferring. Only very occasionally (one in a hundred) is there need for split doses. These are sometimes pregnant women, but are always people who develop frank intoxication ('nodding') 3-6 hours after dosing yet are in withdrawal (huge pupils) before the 24 hour mark. They do just fine on half a dose twice daily but it is a headache under most jurisdictions where at least half of all doses have to be taken under direct supervision, the rest being given as take-away bottles.

All the above must be taken together with advice from your own medical advisors, notably the regular family doctor who is often the only one who knows exactly what is going on. He/she should contact the methadone prescriber (if they are different doctors) and discuss the options. I hope this is helpful.

**Dr. Andrew Byrne, General Practitioner, Drug and Alcohol
(New South Wales, Australia)**

Dear Doctor:

About three months ago, I got on a methadone maintenance program. Instead of being started at the standard 40mg, I was started on 20mg—I think because I was so high when I went in there; I'm not sure. Anyway, 20mg was fine for the first week, then I started getting sick in the morning. I kept increasing my dose 10mg at a time, and the same thing would happen. The

dose would hold me fine for about 5 days, then I would start waking up sick. I was up to 100mg, and I was still waking up sick in the morning. I dose at 8:00 a.m., and by 3:00 a.m. the next morning, I'm sick as a dog.

When I wanted to go up again, they didn't believe that I was sick, so they drew some blood to see what my methadone blood level was. As I suspected, it was low. They told me that because of my metabolism, I'm a "fast metabolizer", and my body is running through the methadone "very quickly". The people at the clinic tell me that if I keep going up, I will eventually find a dose that holds me for the full 24 hours.

At the dose I'm at, already I can't take the constipation. I have to take six stool softeners, a gallon of water, and 1-2 enemas A DAY if I ever want to have a bowel movement.

I never had so much trouble on heroin. My psychiatrist (who, by the way, was the medical director of the same clinic from '75-'85) tells me that no matter what dose I go up to, my body will adjust, and I'll ALWAYS get sick in the morning. He recommended that I detox. I went down to 95mg about three days ago. Mind you, I was already getting sick on 100mg/day. From about 2:00 a.m. until my dose, I'm in full-fledged withdrawal.

What should I do? Is it true that I won't ever reach a dose that holds me? The catch-22 is that at the dose I'm on, I can't tolerate the side effects, but it's not holding me 24 hours. I can't go up; I can't go down. Because my metabolism is so fast, I requested a "split dose", but because I'm new to the clinic, they won't trust me with any evening take-homes. I'm so screwed. I need some advice. I'm much worse off than when I was using heroin: now, I have to go through withdrawal every single day of my life. I want to blow my head off. - **Matt**

Dear Matt:

Relax. Your problems are not impossible ones.

1. Senna or Sennatural or Senekot is the best stool softener for most of my patients. Take it. Get your dose divided.
2. What we do at CAP, in such cases, is divide the dose in two or three portions. At first, I would advise 50mg in the morning and 50mg as long after as you can handle, feeling comfortable. The first day, I would recommend 100 mg as usual, 50 mg 12 hours later, then 50mg the next morning and afternoon from then on.
3. You should protest it to the regulatory agency in the state [and CSAT at the federal level] and protest it to the people who give the MD his license if they do not respond adequately. If the clinic says that this is against the "rules," they are mistaken or they are talking about their rules, which should not prevent good medical treatment. The doctor can ask the regulators for an exception due to your medical situation. The low serum level is in the record. Your complaint of constipation is serious and not unique.

If they do not trust you, they should arrange for you to drink your medication 2 times a day, observed. This anti-patient treatment is what drives patients back to smack. It is unethical. The "rules" cannot be applied with clinical success to every person, and the FDA will grant exceptions to them.

4. You should go to a clinic where they give you a take home split dose. As a second, very stupid, but possible solution, you should go to a clinic where you could dose observed twice a day, 6 hours apart, or more. (At CAP we medicate 5:30 am to 7 pm, for example).

We get exceptions for split doses for new patients every few weeks or so. We do it to get their serum levels up and keep them from using heroin. We think that is the main job that we have. Everything else is secondary.

Being able to hold off on your dose from time to time, may help with the constipation (along with the Senna and water). (**Cont. p. 4**)

**Dr. Marc Shinderman, CAP Quality Care
Chicago, Illinois**

Myths of Methadone (from p. 1).

maintenance, when combined with appropriate medical care can reduce the incidence of complications in the mother or fetus, [such as] the slowing of fetal growth during pregnancy, and illness or death in the newborn infant. Withdrawal from methadone treatment is rarely appropriate during pregnancy, as relapse to illicit drug use is likely to occur.

Methadone maintenance is considered so vital for the health of pregnant opioid-addicted women that new Federal Regulations governing methadone maintenance treatment programs require that these women are given preference for admission and that arrangements are made for proper medical care during pregnancy. Years of experience have shown there is no lasting harm to the child from exposure to methadone during pregnancy.

3. METHADONE GETS INTO THE BONE MARROW, ROTS THE TEETH, AND DEPLETES CALCIUM. TRUE OR FALSE

That is absolutely false. Methadone has been used for the of treatment of opioid-dependency for more than thirty-five years and millions of patients. The effects of methadone on the health of those persons has probably been studied more thoroughly than for any other medication in all of medicine. Dr. Mary Jeanne Kreek, MD, , one of the best known and leading researchers in the field of methadone maintenance has summed up the findings:

"The most important medical consequence of ongoing methadone treatment, in fact, is the marked improvement in general health and nutritional status observed in patients as compared with the status at time of admission to treatment. Most medical complications observed in methadone maintenance patients are either related to ongoing preexisting chronic disease, especially chronic liver disease, the onset of which occurred prior to entry into methadone treatment, or to coexisting new diseases or illnesses or to ongoing polydrug or alcohol use.

In short, people actually grow healthier in methadone maintenance treatment. Just how healthy depends on their condition before treatment and how they take care of themselves during treatment. Persons with certain medical conditions may feel body or bone aches and pains. Sometimes this is due to just getting older. However, such afflictions often go unnoticed during a stressful life of opioid addiction.

Once the person starts generally feeling better in recovery, those aches and pains may be more noticeable, but they are not due to methadone. **Many drug-dependent persons neglect dental care before, and even after, entering addiction**

treatment. Any damage to their teeth has nothing to do with methadone and can be corrected with proper dental treatment.

[Source: Kreek, MJ Health consequences associated with the use of methadone, In: Cooper JR Altman F. Brown; BS, Czechowicz D (eds.) Research on the Treatment of Narcotic addiction: State of the Art (NIDA Research Monograph 83-1201). Rockville, MD: National Institute on Drug Abuse: 1983] 4. **METHADONE SUPPRESSES THE IMMUNE SYSTEM SO THAT THE HIV + METHADONE OR AIDS PATIENT SHOULD BE ENCOURAGED TO WITHDRAW. TRUE OR FALSE**

Research in methadone maintenance treatment patients has demonstrated that **methadone does not make HIV or AIDS worse, nor does methadone interfere with treatment for this viral infection.**

Laboratory experiments reported in 2002 from the University of Pennsylvania found that the HIV virus was able more easily to infect certain cells when methadone was added to the mix in a test tube. Also, when methadone was added to cells in which the HIV infection was inactive, the virus began to grow again. **These cells, however, were not from methadone maintenance patients so nothing can be said here about HIV in such patients. Other research had found that steady doses of methadone actually inhibit viral activity.**

Of interest, the methadone doses used in Pennsylvania experiments were extremely low. **Similarly, other experiments had shown that very low, inadequate doses of methadone can hinder the immune system, possibly allowing infections like HIV to become worse.**

Studies in human subjects-methadone maintenance patients-have shown that methadone is not harmful and, in fact, **may boost recovery from HIV-infected former injection drug users (IDUs) not in methadone maintenance treatment and individuals still injecting illicit drugs. In the methadone-maintained patients, the progression of HIV disease was three times less than in the IDUs and less than the in opioid-free former IDUs not in methadone maintenance treatment.** Importantly, over-time, ten persistent IDUs died of heroin overdoses and 2 drug-free former IDUs relapsed and died--there was no such deaths in methadone maintenance.

Hospital Experience (from p. 1)

where having someone to advocate for me came in handy--he had the nurse contact the hospital doctor that was on call that evening, and the doctor instructed the nurse to dose me. That the doctor had not ordered the methadone dose that day was just an

oversight, but without an advocate to question it, I almost certainly would have missed a dose.

The hospital staff, including the nurses and nurse assistants, were always very caring and friendly. I would hope that if I ever have to be hospitalized again, I would receive such good treatment. I'm sure that there are still doctors out there that undermedicate methadone patients for post-surgical pain, but perhaps my story will give methadone patients hope--that there are doctors and hospitals out there that do provide proper pain management and compassionate care, even if you happen to be a methadone maintenance patient.

Dear Anna (from p. 1).

on 20 mg/d of methadone] you should not have a serious problem with withdrawal when transferring to buprenorphine. Hopefully some patients that have transferred will respond to your inquiry.

Dear Subscribers:

There was no scheduled April issue of Methadone Today. Also, due to hospitalization, there was no May issue, which was scheduled,

Please accept my sincere apologies. I know that many of you are very faithful subscribers, and you are appreciated more than you know.

In ten years, I cannot remember missing a scheduled issue. Be assured, however, that you will receive all nine issues for which you paid. Your subscription will be extended a month.

Thank you for your understanding.

Beth Francisco,
Senior Editor

Access to Buprenorphine Limited

Many opiate addicts interested in obtaining buprenorphine treatment cannot find a doctor willing and able to provide treatment. A major reason for this problem is that the federal law that permits prescription of buprenorphine by private physicians* only allows a given physician to provide buprenorphine treatment for 30 patients at a time. Oftentimes, there are physicians in an area providing buprenorphine treatment, but they are already treating 30 patients and cannot accept new patients.

Federal legislators, in their infinite wisdom, decided to mar the otherwise good buprenorphine bill by limiting the number of patients a given physician could treat, because they were afraid of doctor's offices becoming 'dispensing mills' in business to make a fast buck and not interested in providing quality treatment.

Many methadone patients must see this as a bit of cruel irony. When it comes to methadone treatment providers and federal law, the reasoning of policymakers seems to be turned 180 degrees. Their philosophy is that only accredited OTPs (opiate treatment providers) can provide quality methadone treatment. Given the cost of accreditation and following all the rules and regulations, OTPs usually treat relatively large volumes of patients--virtually every OTP treats way over 30 patients at a given time. Certainly, there is nothing in the federal regulations that protects methadone patients from 'dispensing mills'. Though not its specific intention, the federal regulations encourage the formation of large methadone clinics that treat a large number of patients with a one-size-fits-all philosophy.

On the other hand, there is no good reason why physicians should only be able to provide buprenorphine treatment to 30 patients at a time. This regulation is hurting opiate addicts who cannot find a physician willing to provide buprenorphine treatment, as those providing such treatment are barred from accepting new patients. Furthermore, if legislators really are concerned about quality of treatment, it is time that they realized that the best way to ensure quality of treatment is to make treatment more accessible, and eliminating the 30 patient limit would be a first step. If treatment is available through a large number of treatment providers in a given area, patients could deal with poor quality treatment by finding another physician or facility that will provide better quality treatment. The lack of competition in many areas is one of the reasons that good quality methadone treatment is scarce in many areas of the U.S. Hopefully Congress will see that this 30 patient limit was a mistake and will amend the law accordingly.

**Unlike with methadone treatment, opiate addicts can obtain buprenorphine treatment from an individual physician. In addition,*

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buprenorphine patients are not subjected to many of the rules associated with methadone treatment--for example, buprenorphine patients may be prescribed a month's supply of medication at one time, without having to demonstrate stability or being in treatment for a specific length of time.

In contrast, to provide methadone treatment, a facility or individual physician must be an accredited OTP (opiate treatment provider). Although an individual physician could theoretically become an accredited OTP and provide methadone treatment out of his/her doctor's office, the cost of obtaining accreditation and meeting federal regulations would be prohibitive.

Dear Matt (from p. 2).

You ask if it is true that you won't ever reach a dose that holds you. No, that is ridiculous. You may need to see an actual MMT professional physician who knows how to medicate patients. You have no real problem that common sense cannot deal with. Hold on.

While you are waiting for rational care you can try the dopey but practical stop gap measures of taking meds that will help you on the screwy regime that you are on (100mg/D single dose).

You can take a few tabs of over-the-counter Tagamet, the generic is cimetidine, and you can use a small dose of clonidine at the time when you feel that you are feeling "funky" or might otherwise describe the moment that you know that you will not be feeling great in an hour or two. If you take clonidine when you feel okay or 4 hours before your dose or 8 hours after, it can make you pass out. You should have an MD prescribing the clonidine and she will advise you of the risks, which are real. Do not take clonidine from a friend. Your brains CAN "BLOW OUT" if you take a lot for a few weeks and then stop suddenly. It is not candy. It is not benzos. It is blood pressure medication. It works.

Finally, if none of the above works out, you should come to our clinic, and we will transfer you back as soon as possible--stabilized. What you have to lose in relapse or blowing your brains out is well worth whatever it takes to spend a month or two in Chicago.

Tell me about what medications, alcohol or drugs that you may be taking now. If "some," there may be different answers than the ones above. Ditto for hepatitis or anti HIV meds.

Dr. Marc Shinderman, Center for Addictive Problems (CAP)

Editor's Note: The portion of the original reply that discussed LAAM was omitted--since this was written, LAAM ceased being available.

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