A Tool for Buprenorphine Care

(A series of monthly newsletters about buprenorphine treatment)
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Buprenorphine and HIV Care

Put mildly, opioid addiction and HIV infection have a complex relationship. Drug use can spread the virus. Drug use decreases the efficacy of and adherence to antiretroviral treatment. Drug users are less likely to seek medical care in the first place. And hepatitis C—spread when needles are shared—is a common HIV co-infection, but HIV and hepatitis C treatments interact with one another.

Given the inter-relatedness of opioid addiction and HIV, it makes sense to integrate their care, but this is also complex. It raises questions like: Which provider should prescribe buprenorphine? Where should induction happen? Which patients with HIV should receive buprenorphine? Who should provide counseling, and how often, and who decides? Besides finding answers to these questions, other barriers to such integration can include discomfort of staff who are not yet educated about substance abuse treatment, negative attitudes toward the harm-reduction model, staff feeling overwhelmed by taking on something new, and concerns about drug interactions.

How have programs that have successfully integrated HIV and buprenorphine care overcome these barriers? Simply voicing concerns is a good start. Education—both the formal 8-hour course for physicians and informal training for other staff—assuages many fears as well, especially as it brings to light how much more effective HIV treatment is when opioid dependence is addressed and the advantages buprenorphine treatment offers over methadone maintenance, which tends to be more stigmatizing.

A comprehensive look at this issue was written after a 2004 workshop entitled Buprenorphine and Primary HIV Care. It is posted here [pdf] at HIVforum.org.

Guidance on Inductions

The Physician Clinical Support System (PCSS) has posted new guidance on inductions. “Buprenorphine induction, performed at the right time, remains one of the most satisfying moments a patient and his/her physician can experience,” writes Dr. Paul P. Casadonte, who then describes very concretely what a typical induction looks like and the different forms an induction can take (in terms of level of provider observance). Access this guidance here [pdf], and see the whole list of them here.

Update in Research

- Thomas CP, et al. **Use of buprenorphine for addiction treatment: perspectives of addiction specialists and general psychiatrists.** Psychiatr Serv. 2008 Aug;59(8):909-16. (PubMed ID: 18678689.)
- Esses JL, et al. **Successful transition to buprenorphine in a patient with methadone-induced torsades de pointes.** J Interv Card Electrophysiol. 2008 Aug 7. [Epub ahead of print] (PubMed ID: 18686025.)
- Netherland J, et al. **Factors affecting willingness to provide buprenorphine treatment.** J Subst Abuse Treat. 2008 Aug 19. [Epub ahead of print] (PMID: 18715741.)

Tip of the Month

Buprenorphine can cause orthostatic hypotension, and the effects of that (dizziness, lightheadedness, fainting) may be more pronounced in hot weather. In these last hot days of summer, patients may need to rise more slowly from seated or lying positions, especially in the morning. (Source: suboxone.com)

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