A Tool for Buprenorphine Care

(A series of monthly newsletters about buprenorphine treatment)

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BIV
Buprenorphine Initiative in the VA

Upcoming Trainings and In-Services

PCSS-B is hosting an online training **March 8** at 12pm (Eastern), and it will be led by Dr. Laura McNicholas. She will address induction, stabilization, and switching from methadone. Register here [gotomeeting.com]. More information is available here [pdf].

Research Update

Mouse-over for abstract

Neonatal abstinence syndrome after methadone or buprenorphine exposure. Jones HE, Kaltenbach K, Heil SH, Stine SM, Coyle MG, Arria AM, O'Grady KE, Selby P, Martin PR, Fischer G. N Engl J Med. 2010 Dec 9;363(24):2320-31. PMID: 21142534 Free article

A comparison of buprenorphine induction strategies: Patient-centered home-based inductions versus standard-of-care office-based inductions. Cunningham CO, Giovanniello A, Li X, Kunins HV, Roose RJ, Sohler NL. J Subst Abuse Treat. 2011 Feb 17. [Epub ahead of print] PMID: 21310583

Induction of opioid-dependent individuals onto buprenorphine and buprenorphine/naloxone soluble-films. Strain EC, Harrison JA, Bigelow GE. Clin Pharmacol Ther. 2011 Mar;89(3):443-9. Epub 2011 Jan 26. PMID: 21270789

Buprenorphine Quiz: Training Brush-Up

1. Buprenorphine works because it:
a) is a partial antagonist at the mu-opioid receptor
b) is a full antagonist at the mu-opioid receptor
c) is a partial agonist at the mu-opioid receptor
d) is a full agonist at the mu-opioid receptor

Answer: c. Buprenorphine—while only a partial agonist—has an extremely high affinity for the mu receptor, higher even than methadone and heroin. If buprenorphine is given when another opioid is in a patient's system, withdrawal will be precipitated, thus the reason for waiting until a patient is in moderate withdrawal before induction. Source: DATA-2000 AAAP Training CD-ROM.

2. If a female patient becomes pregnant while on buprenorphine/naloxone:
a) nothing needs to change
b) she should be switched to methadone
c) all pharmacotherapy for opioid dependence is contraindicated
d) she should be switched to the monotherapy (Subutex)

Answer: In flux. Methadone, buprenorphine, and naloxone are all pregnancy category C medications. Methadone is currently considered the treatment of choice for opioid dependence in pregnant women, but several studies have shown that neonatal abstinence syndrome is reduced when the mother is treated with buprenorphine. No well controlled studies have looked at the effect of naloxone on the fetus, so the best option may be to switch from buprenorphine/naloxone (Suboxone) to buprenorphine (Subutex). Sources: 1. DATA-2000 AAAP Training CD-ROM. 2. Jones et al. Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure. N Engl J Med 2010; 363:2320-2331.This article may be viewed for free. See Research Update.

3. Respiratory depression:
a) is a common adverse effect of buprenorphine
b) is a concern in patients who abuse or are at risk of abusing benzodiazepines
c) is prevented by the presence of naloxone
d) is a concern in patients taking therapeutic doses of benzodiazepines

Answer: b. A full agonist (such as methadone) is more likely to cause respiratory depression than buprenorphine, which has a ceiling effect since it is partial agonist. Respiratory depression can occur during treatment with buprenorphine with overdoses of benzodiapines and other CNS depressants. Source: DATA-2000 AAAP Training CD-ROM.

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