A Tool for Buprenorphine Care

(A series of monthly newsletters about buprenorphine treatment)
Volume 3 Issue 12—May 2010

Updated BIV Resource Guide Available

Our resource guide is in its 10th edition! It is easier to navigate and several new questions/answers have been added. Get your copy at the SUD SharePoint site (Buprenorphine folder) or send an email to Margaret Krumm.

New PCSS Clinical Guidelines Available

PCSS-Buprenorphine has posted two new clinical guidelines:
Treatment of Opioid Dependent Adolescents and Young Adults Using Sublingual Buprenorphine
The Off-Label Use of Sublingual Buprenorphine and Buprenorphine/Naloxone for Pain

Download them here: http://pcssbuprenorphine.org/pcss/resources_guidelines.php

Cyber In-Services

Semi-monthly education about buprenorphine

Past presentations are available in the buprenorphine folder at the SUD SharePoint site.

Next in-service topic: Buprenorphine News Update

Please join us on **Friday, July 16 at 2pm Eastern**.
Click here to add the event to your Outlook calendar.
Click here to enter the meeting and view slides. (If asked when logging on, the meeting ID is 'news'.)
To hear audio, call 1-800-767-1750, then enter 13881#.
Slides are available for download from the online meeting interface.

Research Update

Mouse-over for abstract

Integrated opioid use disorder and HIV treatment: rationale, clinical guidelines for addiction treatment, and review of interactions of antiretroviral agents and opioid agonist therapies. Batkis MF, Treisman GJ, Angelino AF. AIDS Patient Care STDS. 2010 Jan;24(1):15-22.

Intrapartum and postpartum analgesia for women maintained on buprenorphine during pregnancy.Meyer M, Paranya G, Keefer Norris A, Howard D. Eur J Pain. 2010 May 3. [Epub ahead of print]

Self-treatment: Illicit buprenorphine use by opioid-dependent treatment seekers.Schuman-Olivier Z, Albanese M, Nelson SE, Roland L, Puopolo F, Klinker L, Shaffer HJ. J Subst Abuse Treat. 2010 Apr 29. [Epub ahead of print]

Efficacy of opiate maintenance therapy and adjunctive interventions for opioid dependence with comorbid cocaine use disorders: A systematic review and meta-analysis of controlled clinical trials. Castells X, Kosten TR, Capellà D, Vidal X, Colom J, Casas M. Am J Drug Alcohol Abuse. 2009;35(5):339-49.

Training Brush-Up: Case study

A 25-year-old man presents to your office requesting treatment with buprenorphine. He is on time, brings the completed forms your office sent him for this initial appointment, is neatly and casually groomed, and polite. He reports that he sniffs heroin daily, last used the previous day, and has been abusing heroin for 3 years. He has not been in any form of treatment before. When asked what happens when he skips a day of use, he reports he has never skipped a day.

The patient has no medical problems, has never seen a psychiatrist or been treated with psychiatric medication and denies any other drug use besides smoking tobacco. He specifically denies benzodiazepine use and rarely drinks alcohol. His physical examination is unremarkable.

What Other Questions Would You Ask? Further history from the patient, especially about his heroin use, would be valuable. When and why did he start using heroin? How does he finance his drug use? How many times each day does he use, and how much does he use each time? It would be good to press him on the question of missing a day

This information is supported and provided by the Substance Use Disorder Quality Enhancement Research Initiative (SUD-QUERI), Center of Excellence in Substance Abuse Treatment and Education (CESATEs), the Mental Illness Research, Education and Clinical Centers (MIRECC), and the Program Evaluation and Resource Center (PERC) within the Department of Veterans Affairs. Please contact Margaret Krumm at margaret.krumm@va.gov or **412-954-5229** with questions or comments.

of use or even going for a 10- to 12-hour period of not using. Has he ever experienced symptoms of withdrawal? If so, what were the symptoms, and how severe were they? How long has it been since he used the previous day? Does he appear to be in withdrawal in your office?

The assessment should also obtain more information about his background. Does he work? Is he married? Does he have children? Does he live with someone who is actively using drugs? Does he have the necessary psychosocial supports? Can medication be safely kept at his home? How will he pay for treatment?

Finally, it would be useful to determine his level of familiarity with other treatment options. What does he know about methadone treatment? Has he considered trying medically supervised withdrawal off opioids? What has he heard about buprenorphine?

The patient reports that he is single, lives by himself, and has no children. He began using pain pills 3 years ago after he hurt his back helping a cousin move. He had difficulty getting a constant supply of the pills. A friend suggested using heroin and initially supplied him with such. He reports his back pain is now essentially gone, but he has become hooked on heroin. He sniffs it twice per day and usually spends about $20 to $30 per day on the drug. He is careful not to go longer than 12 hours without using, as he can go into withdrawal if he does not use. He cannot describe withdrawal, and when told about sample symptoms, he reports sleep disturbance and back pains as his primary symptoms.

He does not work but does receive a small monthly check from a trust fund set up by his grandparents. While it is not much, he is able to get by on it and believes the cost of buprenorphine will be less than what he spends on heroin.

At the time the patient arrived at your office, your staff obtained a supervised urine sample for onsite drug testing. During the visit, your nurse calls and tells you the sample is positive for methadone and benzodiazepines but negative for opioids and cocaine. You inform the patient of these results. He tells you that he did buy a bottle of methadone on the street 2 days ago and that he used a pill to help him sleep but persists in saying he sniffed heroin the previous day.

What Other Information Would You Now Want to Obtain? Further information relevant to the DSM-IV criteria for opioid dependence would be useful at this point. Does he fulfill the criteria for dependence? He fulfills three of the seven DSM-IV criteria for opioid dependence. These include withdrawal, a persistent desire to control use, and important activities given up because of his use. You are on the fence about whether or not he really experiences withdrawal but give him the benefit of the doubt.

Is the Patient a Good Candidate for Office-Based Buprenorphine Treatment? This patient's presentation contains several worrisome features. While he initially seemed like a good candidate for office-based opioid dependence treatment (for example, he arrived on time, completed the necessary forms before coming, and denied other drug use besides opioids), his subsequent presentation has been more problematic. There are several difficulties and concerns at this point.

Concern 1: Diagnosis of Opioid Dependence? Does he have a DSM-IV diagnosis of opioid dependence? He fulfills only the minimum number of criteria (three of seven), and evidence for one of these (withdrawal) is not strong.

Concern 2: Physical Dependence? Does he have physical dependence on opioids?

Again, the evidence for physical dependence (such as a withdrawal syndrome or tolerance) is not particularly persuasive. Furthermore, he has not used since the previous day, and it is reasonable to expect some physical evidence of withdrawal at this time. However, his current exam is unremarkable. Finally, his urine sample is negative for opioids (morphine), although it is positive for methadone. Methadone could suppress his opioid (heroin) withdrawal, but the methadone use was 2 days previous. At this point, he should be showing evidence of withdrawal from the methadone.

Concern 3: Honesty? He has not been truthful about his drug use. He initially told you he only used heroin. It has subsequently been determined that he uses illicit methadone and benzodiazepines. He states that he used heroin the previous day, but his urine sample is negative for opioids (such as morphine, the metabolite of heroin). His urine sample should be positive for opioids if he used the previous day.

Concern 4: In Methadone Treatment? He may be in methadone treatment. It is possible that he is not using illicit methadone but is instead attending a methadone program. He may be seeking a buprenorphine prescription in hopes that he can successfully use it with his methadone or instead of take-home methadone doses (for instance, sell a take-home dose of methadone and take a dose of buprenorphine instead). Methadone programs do not routinely test urine samples for buprenorphine, so the program will not know he is taking it. He may try to time his buprenorphine dose relative to his methadone dosing to avoid precipitated withdrawal with the buprenorphine/methadone interaction.

Concern 5: Benzodiazepine Use? He may be abusing benzodiazepines. Benzodiazepine abuse is a relative contraindication to buprenorphine use.

Given these concerns, at this time, the patient does not appear to be a good candidate for office-based treatment with buprenorphine.

What Would You Tell the Patient? The patient should be told that you would like to refer him to a substance abuse treatment program as the next step in his evaluation and treatment. It can be explained that further evaluation and information is needed and that it is not uncommon for patients to first undergo an attempt at a medically supervised withdrawal before entering longer-term maintenance treatment. Referral to a substance abuse day-hospital program with medically supervised withdrawal would be a good next step, if available.

Source: AAAP DATA-2000 Training

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