

A Tool for Buprenorphine Care

(A series of monthly newsletters about buprenorphine treatment)

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A Must-See Site

Check out BupPractice.com/Resources. While not associated with the VA, this is a no-nonsense, pharma-free place that has aggregated primary literature and other types of resources regarding every angle of treatment with buprenorphine. Search by topic or tag (e.g., "Complicated Patients", "Initial patient contact", "Preinduction") or provider level of experience with buprenorphine (e.g., "Just became waived"). There are continuing education materials, and everything is peer reviewed and updated annually. It is funded by the National Institute on Drug Abuse (NIDA).

Training Brush-Up: Case Study

A 25-year-old Veteran with no significant medical or psychiatric history presents to your office requesting treatment with buprenorphine. He is on time, brings the completed forms your office sent him, and is neatly and casually groomed and polite. He reports that he has sniffed heroin daily for 3 years and last used the previous day. He has not sought treatment before. When asked what happens when he skips a day, he reports he never has, so he cannot really answer the question. He denies all other drug use and specifically denies benzodiazepine alcohol. His physical examination is unremarkable.

He sniffs heroin twice daily and spends about \$20–30 per day on it. He is careful not to go longer than 12 hours without using. He cannot describe withdrawal, and when told about sample symptoms, he reports sleep disturbance and back pains as his primary symptoms.

As you are examining the patient, your nurse calls and tells you his supervised urine sample is positive for methadone and benzodiazepines but negative for opioids and cocaine. You inform the patient, and he admits that he bought a bottle of methadone on the street 2 days ago and a pill to help him sleep, but persists in saying he used heroin the previous day.

Is this patient a good candidate for office-based buprenorphine treatment? Initially, yes (for example, he arrived on time, completed the necessary forms before coming, and denied other drug use besides opioids), but his subsequent presentation has been more problematic.

Concern One: Does he have a DSM-IV diagnosis of opioid dependence? He fulfills only the minimum number of criteria (3/7), and evidence for one of these (withdrawal) is not strong.

Concern Two: Does he have physical dependence on opioids? Again, the evidence for physical dependence 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, but there are no objective signs of opioid withdrawal, such as gooseflesh

or mydriasis. Meanwhile, his urine sample is negative for opioids (morphine), although it is positive for methadone. Methadone could suppress his heroin withdrawal, but the methadone use was 2 days previous. At this point, he should be showing evidence of withdrawal from the methadone.

Concern Three: 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.

Concern Four: 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.

Concern Five: He may be abusing benzodiazepines. Benzodiazepine use 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 this 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.

Adapted from DATA-2000 AAAP Training CD-ROM.