Methadone maintenance: Best clinical practices: trends and models of care

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Long standing issues in practice

- Determination of opioid use disorder
- Start low and go slow with dosing
  - Patience is a virtue for patients and providers
- Knowing when to say “no”
  - Some people are not appropriate for methadone maintenance
- Avoiding “dose creep”
  - What are dose increases addressing?
**A Road-Map to “Steady State”**

Days/Half-Lives – Methadone half-life = 24-36 hours
Dose constant at 30 mg daily.

Interdose interval = 24 hrs (trough to trough)
Peak levels increase daily for 5-6 days with NO increase in dose!

Methadone Dose
“Equivalent Effect”

- Day 1 Thu  Methadone dose 30mg  30mg
- Day 2 Fri  Methadone dose 40mg  55mg
- Day 3 Sat  Methadone dose 50mg  77.5mg
- Day 4 Sun (TH) Methadone dose 60mg  98.75mg
- Day 5 Mon  Methadone dose 65mg  114.375mg
- Day 6 Tue  No Show

Methadone “dose equivalent effect” due to accumulative effect of tissue buildup
Long standing issues in practice

Determination of opioid use disorder

Start low and go slow with dosing
Patience is a virtue for patients and providers

Knowing when to say “no”
Some people are not appropriate for methadone maintenance

Avoiding “dose creep”
What are dose increases addressing?
Obtain releases of information
   Not having the ability to have open collegial
discussions may be dangerous

QTc prolongation risk
   Screening for increased risk

PMP utilization
   Methadone from clinics is not housed on PMPs

Split dosing/Peak and Trough
   Limited need other than pregnant women

Risk Management

   Address all changes in patient status:
   Tox screen results
   ETOH use
   Sedation or impairment and third party responsibilities
### Table 6: Interpreting Methadone SML Values

<table>
<thead>
<tr>
<th>Trough Level</th>
<th>Clinical Effect</th>
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<tbody>
<tr>
<td>≤ 200 ng/mL</td>
<td>Subtherapeutic, withdrawal likely.</td>
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<tr>
<td>&gt; 200-400 ng/mL</td>
<td>Sometimes little or no withdrawal, but opioid blockade probably incomplete.</td>
</tr>
<tr>
<td>&gt; 400-500 ng/mL</td>
<td>Optimal, usually no withdrawal and opioid blockade achieved.</td>
</tr>
<tr>
<td>&gt; 500-700 ng/mL</td>
<td>Withdrawal unlikely, but possible: monitor clinically for overmedication.</td>
</tr>
<tr>
<td>&gt; 700 ng/mL</td>
<td>Withdrawal unlikely, examine other reasons for any discomfort (and monitor for overmedication)</td>
</tr>
</tbody>
</table>

*Patient’s clinical presentation should override SML values.*

*Source: Tenore 2003*
Challenges in 2015:

- Pendulum swinging back to heroin from pill form opioids
- Patients testing negative for opioids but demonstrating withdrawal and IVDU
- Multiple prescribers: “Shared patient management”
- Medical marijuana/Physician as magistrate
- NP restrictions
Pendulum swinging back to heroin from pill form opioids

New preparation of oxycodone still injectable
Availability of pill form opioids decreased

Across CSAC/MRMS’s programs, heroin is the reason for requests for admissions

Patients testing negative for opioids but demonstrating withdrawal and IVDU

Case examples:
40 year old patient presents with multiple IVDU sites, and severe opioid withdrawal symptoms but negative tox screen

35 year old patient presenting with only IN use, severe withdrawal and negative tox screen
Multiple prescribers: “Shared patient management” challenges:

Case Examples: (disclaimer)

- Patient prescribed adderal and klonopin prior to entering treatment for many year history of opioid and THC use.

  Methadone induction is started but patient is noted to be sedated despite continuing to use heroin which suggests that the dose is not sufficient.

  Prescriber refuses to alter doses blaming any sedation on the methadone.

Patient overdoses on heroin.

- Patient on a stable methadone dose is prescribed Celexa which...
Case examples con’t:

• Patient presents to methadone program requesting treatment for heroin use and has a history of HTN and on lasix.

  Clinic requests EKG as part of arrhythmia risk assessment and PCP refuses and declines to refer patient for a cardiology consult.

  Patient ultimately goes to the ER for an EKG which is returned to the clinic with no interpretation.

• Post partum woman on methadone is seen to be falling asleep in the nursery and methadone is reported to be the cause.
Questions For Discussion:

Should all patients have tox screens prior to being started on potentially sedating or abusable psychotropic meds?

What kind of conversations should be taking place between providers?

Very difficult question: does excluding methadone treatment from PMPs place patients at risk?

How do we decrease the potentially dangerous silos of treatment?
Medical Marijuana

ASAM Statement:
In order to think clearly about “medical marijuana,” one must distinguish first between 1) the therapeutic potentials of specific chemicals found in marijuana that are delivered in controlled doses by nontoxic delivery systems, and 2) smoked marijuana.
Second, one must consider the drug approval process in the context of public health, not just for medical marijuana but also for all medicines and especially for controlled substances. Controlled substances are drugs that have recognized abuse potential. Marijuana is high on that list because it is widely abused and a major cause of drug dependence in the United States and around the world. When physicians recommend use of scheduled substances, they must exercise great care. The current pattern of “medical marijuana” use in the United States is far from that standard.

http://www.asam.org/docs/publicy-policy-statements/1medical-marijuana-4-10.pdf
Practical Considerations:

How should treatment programs respond to patients with certificates for medical THC?

How would this effect take home appropriateness?

Education of patients and risk management

Physician as Magistrate:

Allowing patients to drive with or without certificate who use THC
Drug Testing

What Drug Tests Detect...

RECENT DRUG USE - PERIOD.

What Drug Tests do *not* Detect...

- Impairment
- Addiction
- Abuse
- Dependence
NP Practice Restrictions

Since the spring of 2015, neither NPs nor PAs are allowed to alter doses of methadone which they have been doing for decades!

The result: restriction on staff power to address the growing opioid crisis with physicians having to order any and all methadone dose changes.

Programs are only now able to request waivers to allow NPs to resume routine practices.
References:


